MEDICARE A Bulletin
A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

In This Issue...

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Don't Miss the May 2008 Medifest Symposium
Reserve Your Place Today and Attend This Popular Educational Seminar 3

Change In the Amount In Controversy Requirement
Increase in the AIC Required For ALJ and Federal District Court Appeals 5

NPI Required for All HIPAA Standard Transactions
Be Prepared! Test NPI-Only Claims Now 9

Update to Audiology Policies
Clarification to the Language and Coding Issues Related to Audiological Services 15

Local Coverage Determinations
Revision to LCDs and Additional Medical Information 21

Oral Three-Drug Combination Anti-Emetic
Hospital Outpatient Departments May Bill for the Entire Tri-Pack of Aprepitant as Part of a Cancer Chemotherapeutic Regimen 24

Fiscal Year 2008 Billing Requirements for CORFs
Key Points on New Processing Requirements Resulting from the MPFS Final Rule 29

Recalibrating DRG Relative Weights Under the IPPS
Refinements Affecting Cost Reporting for Inpatient Hospital Services 31

Hospital Outpatient Prospective Payment System
Updates to the Medicare Claim Processing Manual and the Medicare Benefits Policy Manuals 33

Features

A Message to Providers 3
About This Bulletin 4
General Information 5
General Coverage 15
Local Coverage Determinations 21
Hospital Services 24
SNF Services 28
CORF Services 29
Provider Audit & Reimbursement 31
Outpatient Prospective Payment System 33
Electronic Data Interchange 40
Educational Resources 47

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

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

Routing Suggestions :

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

Table of Contents

In This Issue 1

From the Fiscal Intermediary
A Message to Providers
2008 Medifest Symposium—Registration Ending Soon 3
About the *Medicare A Bulletin* 4
Quarterly Provider Update 4

General Information
Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeal .. 5
Provider Contact Center Training Closures 5
Allowance Update for the Influenza Virus Vaccine Payment and instruction for Pneumococcal Vaccine 6
Additional Clarification Regarding Processing of Drug Claims with Modifier JW 7
Opportunity to Participate in Third Annual Medicare Contractor Provider Satisfaction Survey Ends in April 7
Update to the Implementation Date for Home Health Agencies Providing Durable Medical Equipment in Competitive Bidding Areas 8

National Provider Identifier
NPI Required for all HIPAA Standard Transactions on May 23, 2008 9
National Provider Identifier—March 1st Milestone 10
What To Do if Your 837P or CMS-1500 Medicare Claim Rejects and More 12
Additional Information on Reporting a National Provider Identifier for Ordering/ Referring and Attending/Operating/Other/ Service facility for Medicare Claims 14

General Coverage
Update to Audiology Policies 15
Clarification on Bone Mass Measurement Billing Requirements 17
Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions 18
Reporting of Hematocrit or Hemoglobin Levels for the Administration of Erythropoiesis Stimulating Agents 20

Local Coverage Determinations
LCD Table of Contents 21

Hospital Services
Clarification on Billing for the Oral Three-Drug Combination Anti-Emetic (Aprepitant) 24
April 2008 Inpatient Rehabilitation Facility Prospective Payment System PRICER Changes 25
Changes to the Long Term Care Hospital PPS PRICER 26

SNF Services
Skilled Nursing Facility Inpatient Part A Billing for No-Payment and Medicare Advantage Claims 28

CORF Services
Comprehensive Outpatient Rehabilitation Facility Billing Requirement Updates for Fiscal Year 2008 29

Provider Audit & Reimbursement
Refinements in Cost Reporting for Recalibrating DRG Relative Weights Under the Inpatient Prospective Payment System 31

Hospital Outpatient PPS
January 2008 Update of the Hospital Outpatient Prospective Payment System 33

Electronic Data Interchange
Claim Status Category Code and Claim Status Code Update 40
Healthcare Provider Taxonomy Code Update Effective April 1, 2008 40
Remittance Advice Remark Code and Claim Adjustment Reason Code Update 41

Educational Resources
Educational Events
Upcoming Provider Outreach and Education Events 47

Preventive Services
March is National Nutrition Month 48
March is National Colorectal Cancer Awareness Month 49

Other Educational Resources
Acute Inpatient Prospective Payment System Fact Sheet now Available 50
Hospital Outpatient Prospective Payment System Fact Sheet now Available 50
The Medicare Appeals Process—Five Levels to Protect Providers 50
Ambulance Fee Schedule Fact Sheet now Available 50
Informational DVD Available for Indian Health Providers 50
Ambulatory Surgical Center Fee Schedule Fact Sheet now Available 51
Hospice Payment System Fact Sheet now Available 51

Order Form – Part A Materials 52

Important Addresses, Telephone Numbers and Web Sites 53

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

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A MESSAGE TO PROVIDERS

2008 MEDIFEST SYMPOSIUM—REGISTRATION ENDING SOON

Registration is still open for the 2008 Medifest Symposium occurring on **May 6 & 7** in Orlando, but spaces are going quickly, so reserve your spot today.

First Coast Service Options, Inc. (FCSO) popular educational seminar brings together Medicare experts, clinicians, billing staff and coders throughout Florida to learn the latest on the Medicare program and to network with peers. Based on your feedback, we designed this year's Medifest with exciting enhancements that you won't want to miss:

- **Two One-day Sessions**. We are offering Medifest as two one-day sessions to accommodate providers' busy schedules and to encourage a variety of participation. The cost is $136 per person, per day.
- **Smaller Class Size and More Interactive Activities.** To ensure an optimal learning experience, we are limiting each class to 40 participants. Classes will also be more interactive this year, with problem-solving activities and real-world scenarios to reinforce your understanding of the curriculum.
- **Advanced Courses and Specialty Topics**. You told us and we listened! This year's Medifest is devoted to more advanced courses and specialty topics targeting experienced Medicare providers. Examples of our new cutting-edge classes include:
    - Better Business through Better Billing
    - E/M Coding
    - Medicare Review/Data Analysis
    - Specialty Classes on Therapy and Rehabilitation, Skilled Nursing Facility, and Independent Diagnostic Testing Facility

To ensure all participants benefit from this advanced curriculum, some courses require completion of prerequisite Web-based Training (WBT) courses. All prerequisites are free, brief and conveniently available through our Learning Management System (LMS) or CMS Web site. Participants cannot register for courses with mandatory prerequisites until they successfully complete them.

For complete instructions on registering for the 2008 Medifest, or to view event location, class offerings and course descriptions, see our Web site at *www.fcso.com*. Under "Medicare Providers," click "Florida Part A or B," then select the "Provider Outreach and Education" tab.

This is the only Medifest this year, and space is limited, so don't forget to register today! ❖

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 Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

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

Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

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

Impact on Providers

This article is based on change request (CR) 5897, which notifies Medicare contractors of an increase in the amount in controversy (AIC) required to sustain administrative law judge (ALJ) and federal district court appeal rights beginning January 1, 2008. ***The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2008 is $110. The amount remaining in controversy requirement for requests made on or after January 1, 2008 is $120. For Federal District Court review, the amount remaining in controversy goes from $1,130 for requests prior to January 1, 2008 to $1,180 for requests on or after that date.***

Background

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended the Medicare claim appeal process. In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for annual reevaluation (beginning in 2005) of the dollar amount in controversy required for an administrative law judge (ALJ) hearing and federal district court review.

Change request (CR) 5897 revises the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or federal district court review. As of January 1, 2008, the amount remaining in controversy must be at least $120 for an ALJ hearing or at least $1,180 for a federal district court review requested on or after January 1, 2008.

Additional Information

The official instruction, CR 5897, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1437CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5897
Related Change Request (CR) Number: 5897
Related CR Release Date: February 5, 2008
Related CR Transmittal #: R1437CP
Effective Date: January 1, 2008
Implementation Date: May 5, 2008

Source: CMS Pub. 100-04, Transmittal 1437, CR 5897

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Provider Contact Center Training Closures

The Florida Part A Provider Contact Center will be closed from 2:00 – 4:00 p.m. on the following dates:

Friday, April 11, 2008

Friday, April 18, 2008

Friday, April 25, 2008

Our customer service representatives will be undergoing training during the above referenced times.

Although our customer service representatives will not be available, the Medicare Part A interactive voice response (IVR) unit will be available as usual at 1- 877-602-8816 (toll-free). ❖

Allowance Update for the Influenza Virus Vaccine Payment and instruction for Pneumococcal Vaccine

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

Provider Types Affected

Physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or A/B MACs) for providing influenza and pneumococcal vaccines to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5910, from which this article is taken, clarifies CR 5744 (Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment Is Based on 95 Percent of the Average Wholesale Price [AWP]), released October 26, 2007. It provides Medicare contractors additional instructions regarding the pediatric pneumococcal vaccine *CPT* code *90669*, and the updated payment allowance for the nasal influenza virus vaccine *CPT* code *90660*.

The Medicare Part B payment allowance for *CPT 90660* is $22.031, effective September 19, 2007. Make sure that your billing staffs are aware of these *CPT* code updates.

Background

CR 5744 (Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment Is Based on 95 Percent of the Average Wholesale Price [AWP]), released October 26, 2007; provided the payment allowances for pneumococcal vaccine *Current Procedural Terminology (CPT)* codes *90732* and, and influenza virus vaccines *CPT* codes *90655, 90656, 90657, 90658*, and *90660*).

CR 5910, from which this article is taken, augments CR 5744 by providing additional instructions regarding pediatric pneumococcal vaccine *CPT* code *90669*, and the updated payment allowance for the nasal influenza virus vaccine *CPT* code *90660*. These changes are:

- ***CPT* Code *90669* – Effective January 1, 2008,** FIs, carriers, and A/B MACs will accept claims containing *CPT* code *90669* for pneumococcal vaccine. In order to facilitate appropriate payment for *CPT* code *90669* (Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use), carriers and A/B MACs will use a payment indicator of "1" and the deductible indicator of "1". Providers should bill HCPCS code G0009 when billing for services on or after January 1, 2008, for the administration of *CPT* code 90669.
- ***CPT* Code *90660* –** On September 19, 2007, the Food and Drug Administration (FDA) approved FluMist® for the 2007-2008 influenza season. Thus, your FI, carrier, or A/B MAC may cover *CPT* code *90660* (FluMist, a nasal influenza vaccine) if it determines that its use is medically reasonable and necessary for the beneficiary. The Medicare Part B payment allowance for *CPT* code *90660* is $22.031, effective September 19, 2007, except where the vaccine is furnished in the hospital outpatient department. This supersedes the allowance figure provided in CR 5744.

Note: All other instructions in CR 5744 remain in effect.

Please note that, except when the vaccine is furnished in the hospital outpatient department, the Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the average wholesale price (AWP), as reflected in the published compendia payment for the vaccine is based on reasonable cost.

Also note that annual Part B deductible and coinsurance amounts do not apply; and that all physicians, nonphysician practitioners, and suppliers who administer the influenza virus and pneumococcal vaccinations must take assignment on the claim for the vaccine.

Finally, your Medicare contractor will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims that you bring to their attention.

Additional Information

You may find more information about the additional information regarding *CPT* codes *90669* and *90660* by going to CR 5910, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1461CP.pdf*.

You might also want to review the *MLN Matters* article related to CR 5744. You may find that article on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf*.

If you have any questions, please contact your 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 1-888-664-4112.

MLN Matters Number: MM5910
Related Change Request (CR) Number: 5910
Related CR Release Date: February 22, 2008
Related CR Transmittal Number: R1461CP
Effective Date: January 1, 2008, except as noted in article.
Implementation Date: No later than March 24, 2008

Source: CMS Pub. 100-04, Transmittal 1461, CR 5910

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Additional Clarification Regarding Processing of Drug Claims with Modifier JW

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

Provider Types Affected

Physicians, providers and suppliers billing Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers and/or durable medical equipment Medicare administrative contractors [DME MACs]) for drugs or biologicals provided to Medicare beneficiaries.

Impact on Providers

When processing all drugs **except those provided under the Competitive Acquisition Program (CAP)** for Part B drugs and biologicals, Medicare contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. This **modifier will provide payment for the discarded drug or biological.**

Background

The Centers for Medicare & Medicaid Services (CMS) issued this CR 5923 to notify providers of the *Medicare Claims Processing Manual* update that clarifies the use of modifier JW when processing all drugs except CAP drugs.

Additional Information

To see the official instruction (CR 5923) issued to your Medicare carrier, DME/MAC, FI and/or A/B MAC, visit on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1478CP.pdf*.

If you have questions, please contact your Medicare carrier, 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 1-888-664-4112.

MLN Matters Number: MM5923
Related Change Request (CR) Number: 5923
Related CR Release Date: March 14, 2008
Related CR Transmittal Number: R1478CP
Effective Date: January 1, 2008
Implementation Date: April 14, 2008

Source: CMS Pub. 100-04, Transmittal 1478, CR 5923

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Opportunity to Participate in Third Annual Medicare Contractor Provider Satisfaction Survey Ends in April

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

Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare fee-for-service (FFS) program who were selected to participate in the Medicare contractor provider satisfaction survey (MCPSS) for 2008.

Provider Action Needed

Those Medicare providers who were selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the MCPSS are asked to please take the time to complete the survey or respond to the survey contractor, Westat, follow-up calls. The survey is designed so that it can be completed in 15 minutes and responses may be submitted via a secure Web site, mail, fax or over the telephone. Currently the average response rate is 32 percent; CMS' goal is to reach a 65 percent response rate. Data collection ends in April.

Background

The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of contractor performance as well as aid future process improvement efforts of Medicare contractors (carriers, fiscal intermediaries, Medicare administrative contractors, (A/B MACs), and durable medical equipment Medicare administrative contractors (DME MACs). Specifically, the survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

The MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The results of the second MCPSS showed that 85 percent of respondents rated their contractors between 4 and 6.

The 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider's overall satisfaction.

Opportunity to Participate in Third Annual Medicare Contractor Provider Satisfaction Survey Ends in April (continued)

"CMS and the Medicare contractor community are committed to high quality relationships with the provider community," CMS Acting Administrator Kerry Weems said in a recent CMS press release. "The MCPSS provides contractors with greater insight into their provider communities, and allows them to make process improvements based on provider feedback."

"The shift from claims processing to provider inquiries as the top predictor of satisfaction is a perfect example of the type of trend data the MCPSS will reveal," Weems said. "Contractors are able to factor this insight into how they prioritize their provider-focused efforts."

Additional Information

To review the complete report of the second MCPSS refer to the CMS Web site at *http://www.cms.hhs.gov/mcpss/downloads/mcpss_report.pdf*.

To review a summary of the 2007 MCPSS refer to the CMS Web site *http://www.cms.hhs.gov/mlnmattersarticles/downloads/se0733.pdf*.

CMS plans to make the survey results publicly available in July 2008.

Further information about the MCPSS is available on the CMS Web site at *http://www.cms.hhs.gov/MCPSS*.

MLN Matters Number: SE0804
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 SE0804

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Update to the Implementation Date for Home Health Agencies Providing Durable Medical Equipment in Competitive Bidding Areas

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

Provider Types Affected

All home health agencies (HHAs) billing Medicare contractors regional home health intermediaries (RHHIs)) for durable medical equipment (DME) provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This change request (CR) 5868 is updating the previously released CR 5551. The *MLN Matters* article related to CR 5551 may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5551.pdf*.

CAUTION – What You Need to Know

The effective and implementation dates in CR 5551 **were originally April of 2008** and CR 5868 changes **those dates to July of 2008**.

GO – What You Need to Do

HHAs may want to review the remainder of this article for information regarding the competitive bidding program for DME under Medicare and take appropriate action based on the impact of this program on your DME billings.

Background

This article and related CR 5868 provides general guidelines for processing HHA claims. Beginning in 2008, in a competitive bidding area, a supplier must be awarded a contract by CMS in order to bill Medicare for competitively bid DME. Therefore, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either:

- Be awarded a contract to furnish the items in this area; or
- Use a contract supplier in the community to furnish these items.

The competitive bidding items will be identified by Healthcare Common Procedure Coding System (HCPCS) codes and the competitive bidding areas will be identified based on ZIP codes where beneficiaries receiving these items maintain their permanent residence. The DME Medicare administrative contractors (DME MACs) will have edits in place indicating which entities are eligible to bill for competitive bid items and the appropriate competitive bid payment amount.

As of July 1, 2008, important points to remember are:

- All suppliers of competitively bid DME **must bill the DME MAC** for these items and will no longer be allowed to bill the RHHIs for competitive bid items.

Update to the Implementation Date for HHA Providing DME in Competitive Bidding Areas (continued)

- Claims submitted to the RHHI for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs who will have jurisdiction over all claims for competitively bid items.
- Claims for DME furnished by HHAs that are not subject to competitive bidding would still be submitted to the RHHIs.

For your reference, the HCPCS codes subject to competitive bidding and a list of ZIP codes and core based statistical areas (CBSAs) applicable to the competitive bidding areas is available on the Internet at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(Pages)/Competitive+Bid+Areas*.

Additional Information

For complete details regarding CR 5868 please see the official instruction (CR 5868) issued to your Medicare A/B MAC, RHHI, or FI. That instruction may be viewed by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1431CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5868
Related Change Request (CR) Number: 5868
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1431CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1431, CR 5868

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National Provider Identifier

NPI Required for all HIPAA Standard Transactions on May 23, 2008

NPI Is Here. NPI Is Now. Are You Using It?

As of May 23, 2008, the national provider identifier (NPI) will be required for all HIPAA standard transactions. This means:

- For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice.
- The reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.

Reminder: May 23rd Is Only Two Months Away, Be Prepared! Test NPI-Only Now

Now that the NPI is required on all Medicare claims in the primary provider fields, if your claims are being successfully processed with NPI/legacy pairs (and most are) now is the time to begin testing claims using the NPI alone.

If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, go into your NPPES record and validate that the information you are sending on the claim is consistent with the information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims three-four days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call the customer service representative at your Medicare carrier, FI, or A/B MAC enrollment staff or your DME MAC to discuss your situation and, if necessary, have it investigated. Have a copy of your NPPES record or your NPI registry record available. The contractor telephone numbers are likely to be quite busy, so don’t wait.

Doing this testing now will allow time for any needed corrections prior to May 23, 2008, the date when only the NPI will be accepted in all provider fields.

NPI Required for all HIPAA Standard Transactions on May 23, 2008 (continued)

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found at the CMS NPI Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

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 *http://www.cms.hhs.gov/NationalProvIdentStand*.

Visit The Medicare Learning Network – It's Free! ❖

Source: CMS Provider Education Resource 200803-12

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National Provider Identifier—March 1st Milestone

The NPI is here. The NPI is now. Are you using it?

Effective March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include a national provider identifier (NPI) will cause the claim to reject!

Background

One of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health & Human Services (HHS) to establish unique national identifiers for providers. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. On March 1, 2008, Medicare claims submitted by physicians and other practitioners, laboratories, ambulance company suppliers, DMEPOS suppliers and others that bill Medicare are required to include the new NPI.

Providers must use this information when they submit their claims to Medicare carriers, A/B Medicare administrative carriers (MACs), and DME MACs when they use certain electronic and paper Medicare claims (specifically the X12N 837P electronic claim and the CMS-1500 paper claims).

Hospitals, skilled nursing facilities, home health care agencies and other such institutional providers were required to begin using their NPI beginning on January 1, 2008.

The deadlines for submitting Medicare claims using the NPI are necessary to help the Centers for Medicare & Medicaid Services (CMS), the Medicare contractors and health care providers prepare for the final May 23, 2008, deadline for full NPI compliance. While the final NPI Rule required compliance on May 23, 2007, CMS stated in the NPI National Contingency Guidance that it will not take enforcement action against covered entities that deploy contingency plans through May 23, 2008, provided that conditions in the Guidance were met.

CMS is anticipating that some providers will experience some problems with claims submitted after March 1 – problems could arise in the following situations:

- The provider does not have an NPI.
- The provider does not submit their NPI on their claim.
- The provider has already received an NPI, but the NPI is not consistent with the provider's enrollment information received by the contractor.

Providers whose claims are rejected and returned to them should immediately contact their contractor before resubmitting that claim or submitting new claims for services provided to Medicare beneficiaries. Contact information for the Medicare contractors may be found at *www.cms.hhs.gov/MLNGenInfo/* under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Current Status

Physicians, nonphysician practitioners, labs, ambulance company suppliers, DME suppliers, and others who traditionally bill carriers and DME MACs (2/22/08).

- About 91.3 percent of Medicare carrier claims and 88.5 percent of DME MAC claims are being submitted with an NPI or NPI/legacy pair in the primary provider identifier fields (these numbers are consistent with institutional provider NPI use before the January 1 change).
- For claims submitted with an NPI, the current reject rate for carrier and DME MAC claims ranges from 1-12 percent, depending on the carrier. CMS has received very few complaints from providers.

Institutional Providers (January 1, 2008, deadline)

- In mid-January, the NPI submission rate jumped to 99 percent – compared to 90 percent in December.
- Currently, the submission rate is over 99.9 percent. Less than 0.1 percent of claims are being rejected for not having an NPI in the appropriate fields.

National Provider Identifier—March 1st Milestone (continued)

The March 1, 2008, Deadline

Expectations for March 1:

- A small portion of claims will continue to be submitted without an NPI. These claims will be rejected. Providers have had over two years to acquire and test their NPI.
- Some rejections may occur because a contractor has not completed processing a provider's enrollment application, submitted by the provider to fix inconsistencies between a provider's NPI and Medicare's provider enrollment files.

Medicare Risk Mitigation

CMS and the Medicare contractors are taking aggressive steps to ensure that providers will be paid for treating Medicare beneficiaries after March 1.

Medicare contractors are enhancing their toll-free phone lines by expanding the number of people available to answer calls. Throughout the month of February, CMS has intensified its planning efforts to assist contractors to prepare for the March 1 implementation date. In February 2008, CMS held a training session with contractor call centers and CMS regional office staff to ensure they are able to address provider inquiries on NPI issues.

Daily calls with the carriers, A/B MACs, and DME MACS are scheduled to monitor the status of successful and rejected claims, inquiries, enrollment backlog status, and other relevant information.

Each contractor has created a NPI coordination team to quickly identify and resolve claims processing issues related to the submission of the NPI or NPI-legacy combination, expedite the processing of enrollment applications, and address other issues that may arise.

CMS has implemented temporary measures to allow the Medicare contractors time to address some of the backlog issues, but at some contractors, more work is needed.

Current Claims Process as of March 1

Currently, most Medicare providers (and their claims clearinghouse vendors) are submitting claims that include their new NPI. For those providers who don't have an NPI, they are submitting claims using their legacy provider numbers. When the claim is submitted, Medicare's computer systems will check to confirm that the claim includes an NPI. If there is no NPI, the claim will be rejected and the provider will receive an error message pointing to the lack of an NPI. If the provider has an NPI, the provider should make sure that the number is on the claim and resubmit the claim. If at that point the claim is again rejected, the provider should immediately contact the Medicare contractor to ensure that all provider records are correct before resubmitting the claim.

Contact information for the Medicare contractors may be found under "Downloads" at *www.cms.hhs.gov/MLNGenInfo/*.

The file is named, "Provider Call Center Toll-Free Numbers Directory."

Medicare contractors expect to be able to handle all incoming calls, but some callers may experience extended hold times. CMS is urging providers to be patient – their issues will be addressed.

The Future – May 23, 2008

With May 23, 2008, less than three months away, CMS and the Medicare health care providers must make sure they are ready for full NPI implementation. Providers must be certain their NPI information and Medicare enrollment information is accurate and up-to-date before that date. Further, if providers' claims are being successfully processed with NPI/legacy pairs (and most are) now is the time for them to begin testing claims using only the NPI. Providers should start with small volumes of these NPI-only claims and gradually increase their submissions. Doing this testing now will allow time for any needed corrections prior to the May 23, 2008, deadline when claims must include the NPI only.

What to do if your 837P and CMS-1500 Claims are Rejected

Check your record in the National Plan and Provider Enumeration System (NPPES)

- Validate that the legacy identifier sent on the claim is reported in the provider/supplier's NPI Registry record. If the legacy identifier is not there, instruct the provider/supplier to add it.
- Validate that the legal business name (if the provider/supplier is an organization) or the legal name (if the provider/supplier is an individual or a sole proprietorship) is correct.
- Validate that the correct entity type was selected by the provider/supplier when applying for the NPI. Individuals obtain an NPI entity type 1. Organizations obtain an NPI as entity type 2.

Note: If you enumerated through the EFI alternative, you should use the NPI Registry to check the content of the NPPES file. Make sure to have the customer service representative at your Medicare contractor verify your supplier tax identification number [TIN]/employer identification number [EIN] as the NPI Registry does not list this information.

If these claims are still rejecting, call your Medicare Contractor.

- Have a copy of the NPPES record in hand. A copy of the NPPES record may be obtained online at *https://nppes.cms.hhs.gov*. The EIN or social security number (SSN) will not be shown on this print out.
- Have the claim reject number and message.
- Be prepared to give the following information:
  1. Legal business name of the organization
  2. Contractor tracking number (if known)
  3. Approximate date (month/year) when the 855-enrollment application was submitted
  4. Provider/supplier TIN or SSN
  5. NPI
  6. Medicare legacy identifier
  7. Practice location on claim (i.e. where is the practice located (e.g., 100 Main St. New Orleans, LA)
  8. Contact information where provider/supplier can be reached if further discussion is needed.

National Provider Identifier—March 1st Milestone (continued)

TEST NPI-ONLY NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the national supplier clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

TRANSCRIPT FROM FEBRUARY 6, 2008 ROUNDTABLE NOW AVAILABLE

The transcript from the February 6, 2008, NPI Roundtable on the FFS Medicare Implementation is now available on the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp*.

NEED MORE INFORMATION?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found at the CMS NPI Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

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.

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Source: CMS Provider Education Resource 200802-20

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WHAT TO DO IF YOUR 837P OR CMS-1500 MEDICARE CLAIM REJECTS AND MORE

THE NPI IS HERE. THE NPI IS NOW. ARE YOU USING IT?

VERIFYING NPPES DATA

The Centers for Medicare & Medicaid Service (CMS) has found a significant number of instances where either the legal business name (LBN) and/or employer identification number (EIN) of an organization health care provider who has been assigned a national provider identifier (NPI) do not match Internal Revenue Service (IRS) records. In some cases, this is caused by health care providers who are individuals who erroneously applied for NPIs as organizations and who reported their social security numbers in the EIN field. As a first step to improving the quality of information in the National Plan and Provider Enumeration System (NPPES), we are requesting that organization health care providers verify their LBN and EIN within NPPES. This is especially important if the organization health care provider is experiencing any Medicare claims processing issues.

IMPORTANT INFORMATION FOR MEDICARE FFS PROVIDERS

Effective March 1, 2008, all 837P and CMS-1500 claims received must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject.

WHAT TO DO IF YOUR 837P OR CMS–1500 CLAIM REJECTS

- Check your record in the National Plan and Provider Enumeration System (NPPES)
  - Validate that the legacy identifier sent on the claim is reported in your NPPES record. If the legacy identifier is not there, it needs to be added.
  - Validate that the LBN for a provider/supplier who is an organization or the legal name for a provider/supplier who is an individual or a sole proprietorship is correct.
  - Validate that the correct entity type was selected at the time of NPI application. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.

Note: If you enumerated through the EFI alternative or submitted a paper NPI application, you should use the NPI registry to check the content of your NPPES record. Make sure to have the customer service representative (CSR) at your Medicare contractor verify your EIN because the NPI registry does not display EINs.)

What To Do if Your 837P or CMS-1500 Medicare Claim Rejects and More (continued)

- If the above validation is successful and your claims continue to reject, call the CSR at your Medicare contractor.
  - Have a copy of your NPPES record or your NPI Registry record in hand. A copy of your NPPES record can be printed from NPPES by going online at *https://nppes.cms.hhs.gov* and using the user ID and password selected when you applied for your NPI. If you obtained your NPI through the EFI alternative or submitted a paper NPI application, you should print your record from the NPI Registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do* . EINs and SSNs are not displayed in the NPI registry.
  - Have the claim reject number and message.
  - Be prepared to give the following information:
    1. LBN of the organization or legal name of the individual
    2. Contractor tracking number (if known)
    3. Approximate date (month/year) when the CMS-855 enrollment application was submitted or last updated
    4. Provider/Supplier Tax Identification Number (EIN or SSN)
    5. NPI
    6. Medicare legacy identifier
    7. Practice location on claim (i.e., where is the practice located (e.g., 100 Main St., New Orleans, LA)
    8. Contact Information where you can be reached if further discussion is needed

Some Clearinghouses Continue to Strip Information From Medicare Claims

It has come to CMS' attention that some clearinghouses continue to strip NPIs, as well as other information, from Medicare claims. If your clearinghouse continues to strip your NPI from your claims for any reason, notify your Medicare contractor immediately so that CMS can work with your clearinghouse to resolve the issue.

In some cases, clearinghouses are stripping the SY qualifier and the SSN from claims that contain an NPI. Based on business requirement 4320.17 (outlined in Transmittal number 204, dated February 1, 2006), the qualifier SY is an acceptable qualifier for use on Medicare claims. See below block for specific details. You should share this information with your clearinghouse if you suspect they are stripping the SY qualifier and the SSN from your claims.

4320.17 Shared systems shall reject as non-compliant with the implementation guide any 837 version 4010A1 claim that contains XX in NM108, the NPI in NM109, and 1C or 1G as applicable in REF01of the same loop, but which lacks another REF01 in the billing or pay-to-provider loop with the EI (EIN) qualifier and number or the SY (SSN, applies to carriers and DMERCs only) qualifier and number to convey the taxpayer identifier.

Test NPI–Only Now

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, go into your NPPES record and validate that the information you are sending on the claim is consistent with the information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or your DME MAC. Have a copy of your NPPES record or your NPI Registry record available. The contractor telephone numbers are likely to be quite busy, so don't wait.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found at the CMS NPI Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

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Source: CMS Provider Education Resource 200803-02

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Additional Information on Reporting a National Provider Identifier for Ordering/Referring and Attending/Operating/Other/Service facility for Medicare Claims

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 March 5, 2008, to remove the parenthetical phrase of "MD and DO" from the "Note" paragraph. All other information remains the same. The *MLN Matters* article MM5890 was published in the February 2008 *Medicare A Bulletin* (page 22).

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items; unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

CAUTION – What You Need to Know

Change request (CR) 5890, from which this article is taken, provides that it is the claim/bill submitter's responsibility to obtain the national provider identifiers (NPIs) from the ordering, referring and attending, operating, other, service facility providers, or purchased service providers. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

GO – What You Need to Do

Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/operating/other/service facility provider/purchased service providers are not obtainable.

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 (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: Physicians and the following nonphysician practitioners: 1) nurse practitioners (NP); 2) clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.

You should be aware that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

Additional Information

You may find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare Claims by going to CR 5890, located on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R235PI.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 1-888-664-4112.

MLN Matters Number: MM5890 – Revised
Related Change Request (CR) Number: 5890
Related CR Release Date: January 18, 2008
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-08, Transmittal 235, CR 5890

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GENERAL COVERAGE

UPDATE TO AUDIOLOGY POLICIES

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

PROVIDER TYPES AFFECTED

Physicians, nonphysician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare administrative contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

IMPACT ON PROVIDERS

This article is based on change request (CR) 5717, which alerts affected providers that there are updates to language in the *Medicare Benefit Policy Manual (MBPM)* chapter 15, sections 80.3 and 230.3 and the *Medicare Claims Processing Manual (MCPM)* chapter 12, section 30.3. These manual changes highlight coding issues, including auditory implants as auditory prosthetic devices, differentiate the functions of speech-language pathologists and audiologists in aural rehabilitation, and discuss policy related to automated hearing testing.

CR 5717 states that:

- Medicare pays for:
  - Audiological diagnostic tests under the benefit for “other diagnostic tests”; and
  - Audiological evaluations, which include tests of tinnitus, auditory processing and osseointegrated devices.
- Medicare does cover treatment for beneficiaries with disorders of the auditory systems as speech-language pathology services.
- Audiological tests may be ordered for any beneficiary when there is suspicion of impairment of the auditory systems, including tinnitus, auditory processing or balance.
- Audiological tests should not be ordered for the purpose of fitting or modifying a hearing aid.
- Audiological **tests are covered** and payable when performed by qualified audiologists.
- Medicare **does not cover audiological treatment**, including hearing aids.

BACKGROUND

The sections of the *MBPM* concerning audiological services had not been updated since the manual was last published in 2003. Since that time, there have been requests for clarification of some of the language. You may review the details of these changes by looking at the revised manual sections, which are attached to CR 5717. The *MBPM* chapter 15 section 80.3 and section 230.3 and the *MCPM* chapter 12 section 30.3 are also attached to CR 5717.

KEY POINTS

The revised *MBPM* chapter 15 sections 80.3 and 230.3 and the revised *MCPM* chapter 12 section 30.3 point out that audiologists and speech-language pathologists each furnish separate services to hearing impaired beneficiaries. Osseointegrated auditory implants are prosthetic devices. **Services using automated devices that do not require the skills of an audiologist are not covered services**. The following are the key points for specific requirements listed in the *MBPM* and the *MCPM*.

Under conditions already noted above, Medicare will pay as follows:

- Medicare will pay for appropriately provided audiological diagnostic tests depending on the reason for the test.
- Medicare will pay audiologists for the global service when audiologists perform both the technical and professional components of services that have both components. The most recent Medicare physician fee schedule for pricing and supervision levels for audiology services may be reviewed on the CMS Web site at *http://www.cms.hhs.gov/PFSlookup/01_Overview.asp#TopOfPage*.
- Medicare will not include diagnostic analysis of implants, (such as cochlear, osseointegrated or brainstem implants, including programming or reprogramming following implantation) in the global fee for the surgery.
- Medicare will pay audiologists for the technical component of audiological tests when they perform only the technical component and a physician or qualified non-physician practitioner provides the professional component of services that have both components.
- Medicare will pay for osseointegrated prosthetic devices under provisions of the applicable payment system. Payment may differ depending upon whether the device is furnished on an inpatient or outpatient basis, by a hospital subject to the outpatient prospective payment system (OPPS), by a critical access hospital (CAH), by a physician’s clinic, or by a federally qualified health center (FQHC).
- Medicare will pay for timed *CPT* codes *92620* and *92621* when billed for appropriately provided evaluation of auditory processing disorders.
- The timed *CPT* code *92506* is one of the “always therapy” codes listed in the *MCPM* that must be furnished by a speech-language pathologist under the standards and conditions for speech-language pathology services (see also the *MBPM* chapter 15, sections 220 & 230). Audiologists may not be paid for these codes.

Update to Audiology Policies (continued)

- Medicare will pay for appropriately provided auditory rehabilitation evaluation as a speech-language pathology benefit when furnished by a speech-language pathologist.
- Medicare will pay for appropriately provided auditory rehabilitation evaluation as a diagnostic test benefit when furnished by an audiologist.
- Medicare will pay for appropriately provided speech-language pathology services after implantation of auditory devices.
- Medicare will pay for appropriately provided services of an audiologist for diagnostic evaluation of cochlear implants. At the time of issuance of CR 5717, the *CPT* codes for diagnostic analysis of cochlear implants are *92601, 92602, 92603 and 92604*.

Medicare will NOT pay for:

- Medicare will not pay for diagnostic evaluation of cochlear implants by speech-language pathologists, or others who are not audiologists, with the exception of physicians and nonphysician practitioners who may personally provide the services that are within their scope of practice.
- Medicare will not pay for services documented as audiological services when they have been furnished through the use of computers that do not require the skills of an audiologist.
- Medicare will not pay audiologists for treatment services.
- Medicare will not pay for diagnostic audiological tests provided by technicians unless the order specifies each test individually. Note that technicians must meet qualifications determined by the Medicare contractor being billed, which will include, at a minimum, qualification requirements of state and/or local law and successful conclusion of a curriculum including both classroom training and supervised clinical experience administering the audiological service. (However, when an audiologist does the tests and the orders do not name specific tests, the audiologist may select the appropriate battery of tests.)
- Medicare will not pay for services that require the skills of an audiologist when furnished by an AuD 4th year student who is not qualified according to section 1861(ll)(3) of the Act.
- Medicare will not pay for audiological services incident to the service of a physician or nonphysician practitioner.
- Medicare will not pay for the technical component of audiological diagnostic tests performed by a qualified technician unless the medical record contains the name and professional identity of the technician who actually performed the service and the physician or non-physician supervisor who provides the direct supervision has documented the clinical decision making and active participation in delivery of the service.
- Medicare will not pay for computer-controlled hearing tests that are screening tests, which do not require the skilled services of an audiologist and are not covered or payable using codes for diagnostic audiological testing. Examples include, but are not limited to, otograms and pure tone or immitance screening devices that do not require the skills of an audiologist.

ADDITIONAL INFORMATION

There are actually two transmittals issued to your Medicare contractor for CR 5717. The first contains changes to the *MCPM* and is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1470CP.pdf*.

The second has the changes to the *MBPM* and is available on the same site at *http://www.cms.hhs.gov/Transmittals/downloads/R84BP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5717
Related Change Request (CR) Number: 5717
Related CR Release Date: February 29, 2008
Related CR Transmittal Number: R84BP and R1470CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1470, CR 5717

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CLARIFICATION ON BONE MASS MEASUREMENT BILLING REQUIREMENTS

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 bone mass measurement (BMM) services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on change request (CR) 5847, which clarifies the claims processing instructions contained in CR 5521. Only those business requirements changing from CR 5521 are listed in CR 5847, and the BMM benefit policy is not changing. The basic clarification is that Medicare allows codes other than *CPT* code *77080* (i.e., *76977*, *77078, 77079, 77081, 77083*, and G0130) to be paid even though claims for such services report both a screening diagnosis code and an osteoporosis code.

BACKGROUND

The Social Security Act (Sections 1861(s)(15) and (rr)(1)) (as added by the Balanced Budget Act of 1997 (BBA; section 4106)) standardize Medicare coverage of medically necessary BMMs by providing for uniform coverage under Medicare Part B. Effective for dates of service on and after January 1, 2007, the calendar year (CY) 2007 Medicare physician fee schedule (MPFS) final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry as it is not considered reasonable and necessary under the Social Security Act (Section 1862 (a)(1)(A)). Finally, it required in the case of monitoring and confirmatory baseline BMMs, that they be performed with a dual-energy X-ray absorptiometry (axial) test.

The Centers for Medicare & Medicaid Services (CMS) issued CR 5521 (transmittal 70; May 11, 2007) to provide benefit policy and claims processing instructions for BMM tests. CMS has learned that the updated policy described in CR 5521 is not being implemented uniformly and some covered services are being denied in error.

You may review the *MLN Matters* article related to CR 5521 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5521.pdf*.

CR 5847 clarifies the claims processing instructions contained in CR 5521 and lists only those business requirements changing from CR 5521. The key clarifications are as follows, effective for dates of services on and after January 1, 2007, the following apply to BMM:

- Certain BMM tests are covered when used to screen patients for osteoporosis subject to the frequency standards described in section 80.5.5 of the Medicare *Benefit Policy Manual*, which may be found on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.
- Medicare Contractors will pay claims for screening tests when coded as follows:
  - Contains *Current Procedural Terminology (CPT)* procedure code *77078, 77079, 77080, 77081, 77083, 76977* or HCPCS code G0130, and
  - Contains a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. Contractors are to maintain local lists of valid codes for the benefit's screening categories.
- Contractors will deny claims for screening tests when coded as follows:
  - Contains *CPT* procedure code *77078, 77079, 77081, 77083, 76977* or HCPCS code G0130, but
  - Does not contain a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Dual-energy X-ray absorptiometry (axial) tests are covered when used to monitor FDA-approved osteoporosis drug therapy subject to the two-year frequency standards described in section 80.5.5 of the *Medicare Benefit Policy Manual*.
- Contractors will pay claims for monitoring tests when coded as follows:
  - Contains *CPT* procedure code *77080*, and
  - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code.
- Contractors will deny claims for monitoring tests when coded as follows:
  - Contains *CPT* procedure *code 77078, 77079, 77081, 77083, 76977* or HCPCS code G0130, and
  - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code, but does not contain a valid ICD-9-CM diagnosis code from the local lists of valid ICD-9-CM diagnosis codes maintained by the Medicare contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Single photon absorptiometry ***tests are not covered.*** Contractors will deny *CPT* procedure code *78350*.

Note: As mentioned, these are clarifications and the BMM benefit policy is not changing. Also, note that while Medicare contractors will not search their files to reprocess claims already processed, they will adjust claims that you bring to their attention.

Clarification on Bone Mass Measurement Billing Requirements (continued)

Additional Information

The official instruction, CR 5847, issued to your Medicare 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/R1416CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5847
Related Change Request (CR) Number: 5847
Related CR Release Date: January 18, 2008
Related CR Transmittal Number: R1416CP
Effective Date: January 1, 2007
Implementation Date: February 20, 2008

Source: CMS Pub. 100-04, Transmittal 1416, CR 5847

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Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions

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 March 18, 2008, to correct the bullet regarding the "Maintenance of ESA therapy" (see bullet paragraph in **bold** for easy identification). It should have stated that the "starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) four weeks after initiation of therapy and the rise in hemoglobin is **>** 1g/dL (hematocrit > 3%)." All other information remains the same. The *MLN Matters* article MM5818 was published in the March 2008 *Medicare A Bulletin* (pages 16-17).

Provider Types Affected

Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC] and durable medical equipment Medicare administrative contractors [DME MAC]) for administering or supplying erythropoiesis stimulating agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

What You Need to Know

Following a national coverage analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a decision memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

Change request (CR) 5818 communicates the NCA findings and the coverage policy in the national coverage determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007,do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

Background

Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

Reasonable and Necessary ESA Use

CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions (continued)

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%).
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the 150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha.
- **Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) four weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%).**
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over four weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25 percent. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment.
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any two-week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25 percent from the previously administered dose.
- ESA treatment duration for each course of chemotherapy includes the eight weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use

Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis.
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Anemia of cancer not related to cancer treatment.
- Any anemia associated only with radiotherapy.
- Prophylactic use to prevent chemotherapy-induced anemia.
- Prophylactic use to reduce tumor hypoxia.
- Erythropoietin-type resistance due to neutralizing antibodies.
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

Claims Processing

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an advance beneficiary notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare summary notice 15.20, *The following policies [NCD 110.21] were used when we made this decision*, and remittance reason code 50, *These are non-covered services because this is not deemed a 'medical necessity' by the payer*. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions (continued)

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21.

Medicare contractors will not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

Additional Information

This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction, CR 5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf*.

The second transmittal revises the *Medicare Claims Processing Manual* and it is on the same site at *http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.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 1-888-664-4112.

MLN Matters Number: MM5818 – Revised
Related Change Request (CR) Number: 5818
Related CR Release Date: January 14, 2008
Related CR Transmittal Number: R80NCD and R1413CP
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Source: CMS Pub. 100-04, Transmittal 1413, CR 5818

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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*, Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

MORE INFORMATION

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

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

AJ9170: Docetaxel (Taxotere®) 22
AJ9355: Trastuzumab (Herceptin®) 22

Additional Medical Information

Coverage for Three-D rendering *CPT* Codes *76376* and *76377* 23

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*.

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ADDITIONS/REVISIONS TO EXISTING LCDs

AJ9170: Docetaxel (Taxotere®)—Revision to the LCD

The local coverage determination (LCD) for docetaxel (Taxotere®) was last updated on May 24, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, for docetaxel – J9170.

A revision was made updating FDA-approved verbiage for locally advanced squamous cell carcinoma of the head and neck by removing the word "inoperable" from this indication under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. This indication now reads as follows:

- Docetaxel in combination with cisplatin and fluorouracil is indicated for the induction treatment of patients with locally advanced squamous cell carcinoma of the head and neck.

In addition, under the "Bill Type Codes" section of the LCD, type of bill 22x was added and 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 September 28, 2007.** The full-text of this LCD (L25114) is available through our provider education Web site *http://www.fcso.com*. ❖

AJ9355: Trastuzumab (Herceptin®)—Revision to the LCD

The local coverage determination (LCD) for trastuzumab (Herceptin®) was last updated on May 24, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, for trastuzumab – J9355.

Revisions for FDA-approved indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and included a new indication for adjuvant breast cancer following multi-modality anthracycline based therapy. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated, and "Dosage and Administration" information was added under the "Utilization Guidelines" section of the LCD.

Effective Date

This revision is effective for services provided **on or after January 18, 2008**. The full text of this LCD (L25127) is available through our provider education Web site *http://www.fcso.com*. ❖

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 Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

ADDITIONAL MEDICAL INFORMATION

COVERAGE FOR THREE-D RENDERING *CPT* CODES *76376* AND *76377*

Currently, Medicare does not have a national or local coverage determination addressing coverage for three-dimensional rendering procedures performed in an inpatient or outpatient hospital setting. In lieu of a specific national or local coverage determination, Medicare applies the *Current Procedural Terminology (CPT)* coding system developed by the American Medical Association (AMA).

The *CPT* coding system indicates that codes *76376* and *76377* must be used when three-D rendering is performed. However, these codes must be reported in conjunction with code(s) for base imaging procedure(s). The *CPT* descriptors for *CPT* codes *76376* and *76377* are:

76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation. (Do not report 76376 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75557-75564, 75635, 76377, 78000-78999, 0066T, 0067T, 0144T-0151T, 0159T)*

76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation. (Do not report 76377 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75557-75564, 75635, 76376, 78000-78999, 0066T, 0067T, 0144T-0151T, 0159T)*

In addition, three-D rendering procedures should not be used when the three-D is not medically necessary. For example, do not use *CPT* code *76376* or *76377* when equivalent information was obtained from test already provided by another procedure such as:

- Magnetic resonance imaging
- Ultrasound, angiography, etc.
- A standard CT scan (two-dimensional without reconstruction).

When providing three-D rendering of an original imaging procedure, the results need to be documented in a separate report or in a separate section of the radiological report. ❖

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Hospital Services

Clarification on Billing for the Oral Three-Drug Combination Anti-Emetic (Aprepitant)

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5655, which clarifies that hospital outpatient departments may bill the entire tri-pack of aprepitant, an oral anti-emetic drugs given in conjunction with two other anti-emetic drugs to their FI or A/B MAC as part of a cancer chemotherapeutic regimen that includes the anti-emetic three-drug combination.

CAUTION – What You Need to Know

If the three-drug anti-emetic combination (aprepitant, a 5-HT3 antagonist (e.g. granisetron, ondansetron, or dolasetron), and dexamethasone (a cortico-steroid)) is administered to a beneficiary, the hospital may dispense the tri-pak of three days of aprepitant in a hospital outpatient setting; the tri-pak may then be billed to the FI as 57 units of J8501 (aprepitant, 5mg, oral), in addition to the other two drugs.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) states that reimbursement will be provided for oral anti-emetic drugs when used as a full therapeutic replacement for intravenous dosage forms as part of a cancer chemotherapeutic regimen when the drugs are administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

The oral three-drug combination (tri-pak) is:

- Aprepitant
- A 5-HT3 antagonist (e.g. granisetron, ondansetron, or dolasetron)
- Dexamethasone (a cortico-steroid).

Note: Oral anti-emetic drug(s) should be prescribed only on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24-hour or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment.

The three-drug combination protocol requires the first dose to be administered before, at, or immediately after the time of the anti-cancer chemotherapy administration. The second day, on which only aprepitant is given, is defined as "within 24 hours," and the third day, on which only aprepitant is given, is defined as "within 48 hours" of the chemotherapy administration. These drugs may be supplied by the physician in the office, by an inpatient or outpatient provider (e.g., hospital, critical access hospital, or skilled nursing facility), or through a supplier, such as a pharmacy. (See the revised *Medicare Claims Processing Manual*, chapter 17, section 80.2 (Oral Anti-Emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regimen, which is attached to CR 5655.)

It has come to the attention of CMS that some Medicare contractors are denying payment for the entire tri-pak because two doses of the tri-pak (for days 2 and 3) are sent home with the beneficiary. This is a misinterpretation of CR 4301 (Billing for Take Home Drugs; *http://www.cms.hhs.gov/Transmittals/Downloads/R882CP.pdf*), which requires billing drugs that are for take home use only to the durable medical equipment Medicare administrative contractors (DME MACs).

The purpose of CR 5655 is to clarify that hospital outpatient departments may bill the entire tri-pack of oral anti-emetic drugs to their FI or A/B MAC as part of the three drug combination oral anti-emetic. If the three-drug combination is dispensed with a tri-pak of aprepitant in a hospital outpatient setting, the entire tri-pak may be billed to the FI as 57 units of J8501 (aprepitant, 5mg, oral), and all of the drugs in the three-drug combination must be billed in the same claim.

This clarification is needed to prevent incorrect denials of claims from hospital outpatient departments for aprepitant for chemotherapy-induced emesis, as spelled out in the national coverage determination (NCD), CR 3831 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R40NCD.pdf*.

CR 5655 further instructs that:

- Your FI or A/B MAC is to accept claims for 57 units of aprepitant (J8501) when dispensed to the beneficiary by the hospital in the form of a tri-pak
- Coverage of aprepitant is dependent upon the beneficiary's receipt of a highly emetogenic anti-cancer chemotherapeutic agent

Clarification on Billing for the Oral Three-Drug Combination Anti-Emetic (Aprepitant) (continued)

- For dates of service on or after January 1, 2008, qualifying emetogenic anti-cancer chemotherapeutic agents are:
  - Carmustine, (J9050)
  - Cisplatin, (J9060, J9062)
  - Cyclophosphamide, (J9070, J9080, J9091, J9092, J9093, J9094, J9095, J9096, J9097)
  - Dacarbazine, (J9130, J9140)
  - Mechlorethamine, (J9230)
  - Streptozocin, (J9320)
  - Doxorunicin, (J9000, J9001)
  - Epirubicin, (J9178)
- Coverage of aprepitant is as part of the three drug combination of:
  - Aprepitant (Emend®) (J8501)
  - A 5-HT_3 antagonist, e.g. Granisetron (Q0166), Ondansetron (Q0179), or Dolasetron (Q0180)
  - Dexamethasone, a cortico-steroid (J8540).

All of the drugs must be billed on the same claim.

Effective for dates of service April 4, 2005, through December 31, 2007, inclusive, the following HCPCS dispensed by non-outpatient prospective payment system (OPPS) providers qualify the beneficiary to receive the three drug combination oral anti-emetic: J9050, J9060, J9062. J9070, J9080, J9091, J9092, J9093, J9094, J9095, J9096, J9097, J9130, J9140, J9230, J9320, J9000, J9001, and J9178. For the same time period, the following HCPCS dispensed by OPPS providers qualify the beneficiary to receive the three-drug anti-emetic: J9050, J9060, J9070, J9093, J9130, J9230, J9320, J9000, J9001, and J9178.

Note that CR 5655 instructs your Medicare FI or A/B MAC to adjust denied or partially denied aprepitant (J8501) claims if you bring such claims to the attention of your FI or A/B MAC within six months of the implementation date of January 7, 2008. During this period, the timely filing requirements will be bypassed, as needed, to complete the adjustment.

Additional Information

The official instruction, CR 5655, 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/R1281CP.pd*.

CR 5655 includes some billing examples.

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 1-888-664-4112.

MLN Matters Number: MM5655
Related Change Request (CR) Number: 5655
Related CR Release Date: July 6, 2007
Related CR Transmittal Number: R1281CP
Effective Date: April 4, 2005
Implementation Date: January 1, 2008

Source: CMS Pub. 100-04, Transmittal 1281, CR 5655

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April 2008 Inpatient Rehabilitation Facility Prospective Payment System Pricer Changes

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

STOP – Impact to You

This article is based on change request (CR) 5965, which instructs Medicare contractors to install the April IRF prospective payment system (PPS) PRICER.

CAUTION – What You Need to Know

CR 5965 updates the fiscal year 2008 (FY08) standard payment conversion factor from $13,451 to $13,034, effective for discharges on or after April 1, 2008, and it adds the default case mix group (CMG) of A9999 as a valid CMG to allow "informational only" claims for Medicare Advantage (MA) patients to be processed, effective for discharges on or after October 1, 2006.

GO – What You Need to Do

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

Background

The purpose of CR 5965 is to:

- Update the standard payment conversion factor per the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (Section 115).
- Provide hospitals with a mechanism to submit "informational only" bills to Medicare for Medicare Advantage (MA) patients.

April 2008 Inpatient Rehabilitation Facility Prospective Payment System PRICER Changes (continued)

The following background is provided regarding these issues:

Fiscal Year 2008 Standard Payment Conversion Factor (Effective October 1, 2007)

On August 24, 2007, the Centers for Medicare & Medicaid Services (CMS) issued CR 5694 to outline the prospective payment rates applicable for IRFs, effective for FY 2008. CR 5694 also instructed the standard system maintainer to install the new IRF PPS PRICER that contained updated FY 2008 rates, which set the standard payment conversion factor (also known as the standard federal rate) at $13,451. You may review the *MLN Matters* article related to CR 5694 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5694.pdf*.

"Informational Only" Billing for Medicare Advantage (MA) Patients (Effective October 1, 2006)

On July 20, 2007, CMS issued CR 5647 to require hospitals to submit "informational only" bills to their Medicare contractor for the MA patients they treat, in order for the days to be eventually captured in the disproportionate share hospital (DSH) (or low income patient [LIP] for IRF) calculations. You may review the *MLN Matters* article related to CR 5647 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5647.pdf*.

Standard Payment Conversion Factor Update

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 115) amended the Social Security Act (Section 1886(j)(3)(C)) to apply a 0.0 percent increase to payment rates for IRFs for part of FY 2008. You may find Section 1886(j)(3)(C) of the Social Security Act on the Internet at *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*.

Note: The new rates will become effective for discharges occurring on or after April 1, 2008, and will apply to the last two quarters of FY 2008 (from April 1, 2008 through September 30, 2008).

Payment rates for the first two quarters of FY 2008 (from October 1, 2007 through March 31, 2008) will continue to be based on the 3.2 percent market basket increase that was implemented in the FY 2008 IRF PPS final rule (72 FR 44284). You may review 72 FR 44284 on the Internet at *http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3789.pdf*.

Effective April 1, 2008, the new IRF standard payment conversion factor will be $13,034. Applying this new standard payment conversion factor to the case-mix group relative weights published in the FY 2008 IRF PPS final rule (72 FR 44284, 44293 through 44297) results in the new IRF payment rates listed on the CMS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage*.

You may review 72 FR 44284 and 72 FR 44293 through 44297 on the Internet at *http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3789.pdf*.

"Informational Only" Billing for MA Patients

For IRF "informational only" claims (type of bill 111 with a condition code 04) for MA patients with discharges on or after October 1, 2006, CMS is instructing IRFs to submit a default case mix group (CMG) code of A9999.

Note: Prior to the implementation of this CR 5965, CMS has been instructing IRFs, on a case-by-case basis, to use any CMG until a default Health Insurance Prospective Payment System (HIPPS) code could be considered a valid CMG in the IRF PRICER software.

In summary, CR 5965 instructs your Medicare contractor to:

- Update the FY 08 standard payment conversion factor from $13,451 to $13,034, effective for discharges on or after April 1, 2008.
- Add the default CMG of A9999 as a valid CMG to allow "informational only" claims for MA patients to be processed, effective for discharges on or after October 1, 2006.

In addition, CR 5965 instructs your Medicare contractor to install and pay IRF claims with the April 2008 IRF PPS PRICER.

Additional Information

The official instruction, CR 5965, 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/R1479CP.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 1-888-664-4112.

MLN Matters Number: MM5965
Related Change Request (CR) Number: 5965
Related CR Release Date: March 14, 2008
Related CR Transmittal Number: R1479CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1479, CR 5965

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Changes to the Long Term Care Hospital Prospective Payment System Pricer

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

Provider Types Affected

Long-term care hospitals 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) 5955, which instructs that effective for discharges occurring on or after April 1, 2008, through June 30, 2008, the federal rate for rate year (RY) 2008 will be $38,086.04, and the revised high cost outlier fixed-loss amount is $20,707.

Background

The Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted on December 29, 2007:

- Postponed implementation of a portion of the short stay outlier (SSO) payment adjustment formula effective upon enactment for a period of three years.
- Revised the federal rate for RY 2008 by providing that the base (that is, federal) rate for RY 2008 be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007 (applicable to discharges occurring on or after April 1, 2008).

Note that the Centers for Medicare & Medicaid Services (CMS) made the change to the SSO policy immediately, and the updated long-term care hospital (LTCH) PRICER was in production within the Medicare claims processing system on January 28, 2008. In addition, Medicare contractors were instructed to reprocess SSO claims within 60 days.

The federal rate for RY 2007 was $38,086.04. Consequently, the federal rate for RY 2008 will also be $38,086.04 (effective for discharges occurring on or after April 1, 2008 and on or before June 30, 2008).

In order to maintain estimated total payments for high cost outlier cases at eight percent of the estimated total payments, the revised high cost outlier fixed-loss amount is $20,707 (effective for discharges occurring on or after April 1, 2008 and on or before June 30, 2008). This is consistent with the existing regulations at 42 CRF 412.525(a).

Additional Information

The official instruction, CR5955, 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/R1474CP.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 1-888-664-4112.

MLN Matters Number: MM5955
Related Change Request (CR) Number: 5955
Related CR Release Date: March 7, 2008
Effective Date: April 1, 2008
Related CR Transmittal Number: R1474CP
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1474, CR 5955

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SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY INPATIENT PART A BILLING FOR NO-PAYMENT AND MEDICARE ADVANTAGE CLAIMS

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

PROVIDER TYPES AFFECTED

Skilled nursing facilities (SNFs) that bill Medicare administrative contractors (A/B MACs) or fiscal intermediaries (FIs) for SNF services provided to Medicare beneficiaries enrolled in traditional Medicare or a Medicare Advantage (MA) plan.

IMPACT ON PROVIDERS

This article is informational in nature and meant to clarify existing Medicare policies.

BACKGROUND

A SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of service but continue to reside in a Medicare-certified area of the facility. CMS maintains a record of all inpatient and to keep track of the beneficiary's Part A benefit period.

KEY POINTS

This article is based on change request (CR) 5840, which provides clarification to chapter 6 of the *Medicare Claims Processing Manual,* SNF Inpatient Part A Billing. There is no change in policy. The key points clarified by CR 5840 are:

- If a facility has a separate, distinct non-skilled area or wing, then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no-payment bills would not be required. In addition, SNF consolidated billing legislation for therapy services would not apply to these beneficiaries.
- SNF providers are not required to submit no-payment bills for non-skilled beneficiary admissions.
- SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and drop to a non-covered level of care but continue to reside in a Medicare-certified area of the facility.
- Note that providers may bill benefits exhaust and no payment claims using the default HIPPS code of AAA00 in addition to an appropriate room and board revenue code only.
- SNF providers are not required to submit no-payment bills for beneficiaries that are in current Medicare Advantage (MA) plans and no longer require skilled care while still under the plan.
- If a beneficiary no longer requires skilled care under the MA plan, the SNF may discharge the patient using a patient status code of 04. If the beneficiary then requires skilled care again after a period of non-skilled care, the SNF should begin a new admission claim for Medicare to continue the spell of illness.
- When admitting an MA beneficiary, if a SNF is non-participating with the MA plan, the beneficiary must be notified of his or her status because he/she may be private pay in this circumstance, depending upon the type of MA plan in which the beneficiary is enrolled.
- No-payment bills may span both Medicare and the provider's fiscal year end dates.

ADDITIONAL INFORMATION

To see the official instruction, CR 5840, issued to your Medicare FI or A/B MAC, go to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1394CP.pdf*.

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 1-888-664-4112.

MLN Matters Number: MM5840
Related Change Request (CR) Number: 5840
Related CR Release Date: December 14, 2007
Related CR Transmittal Number: R1394CP
Effective Date: October 1, 2006
Implementation Date: March 17, 2008

Source: CMS Pub. 100-04, Transmittal 1394, CR 5840

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CORF Services

Comprehensive Outpatient Rehabilitation Facility Billing Requirement Updates for Fiscal Year 2008

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

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5898 to bring attention to the implementation of the new claims processing requirements for CORF provider claims (bill type 75x) as a result of the fiscal year (FY) 2008 Medicare physician fee schedule (MPFS) final rule.

CAUTION – What You Need to Know

The MPFS specifies changes applicable to CORF billing. Read the *Key Points* section of this article so that you are aware of the billing requirements for CORF 75x bill types.

GO – What You Need to Do

Make certain your billing staffs are aware of these changes as claims that do not follow the instructions will be returned to you.

Key Points of Change Request 5898

- **Allowable Revenue Codes on CORF Bill Types 75x –** Effective July 1, 2008, the following revenue codes are allowable for reporting CORF services on bill types 75x:

0270	0274	0279	029x	0410	0412
0419	042x	043x	044x	0550	0559
0560	0569	0636	0771	0900	0911
0914	0919				

  Note: Billed revenue codes not listed in the above list will be returned by Medicare systems. See Chapter 25, *Completing and Processing the CMS-1450 Data Set*, for revenue code descriptions. Chapter 25 may be reviewed on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf*.

- **Billing for Social Work and Psychological Services in a CORF –** CORF providers should bill social work and psychological services using only *CPT* code *96152*; health and behavior intervention, each 15 minutes, face-to-face; Individual. *CPT* code *96152* may only be billed with revenue code 0560, 0569, 0900, 0911, 0914 and 0919.

- **Billing for Respiratory Therapy Services in a CORF –** CORF providers should bill respiratory therapy services with revenue codes 0410, 0412 and 0419 only**.**

- **Billing for CORF Nursing Services –** CORF nursing services should be billed with HCPCS code G0128 with revenue codes 0550 and 0559 only. (The requirement to use HCPCS G0128 is not a new requirement for 2008.)

- **Payment of Drugs, Biologicals, and Supplies in a CORF**
  - Influenza, pneumococcal, and hepatitis B vaccine administrations should be billed with revenue code 0771 for which Medicare will pay based on the Medicare physician fee schedule amount for *CPT* code *90471*.
  - HCPCS G0128 should no longer be used for billing the vaccine administration in the CORF setting.
  - CORFs should not bill for supplies they furnish when those supplies are part of the practice expense for that service. Under the MPFS, nearly all these expenses are taken into account in the practice expense relative values. However, CORFs may bill separately for certain splint and cast supplies, represented by HCPCS codes Q4001 through Q4051, when furnishing a cast/strapping application service in the *CPT* code series *29000* through *29750*.

Claims for services rendered on or after July 1, 2008 submitted by CORFs via the bill type 75x that do not comply with these revised requirements will be returned to the CORF.

Additional Information

To see the official instruction (CR 5898) issued to your Medicare FI, or A/B MAC refer to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1459CP.pdf.*

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 1-888-664-4112.

Comprehensive Outpatient Rehabilitation Facility Billing Requirement Updates for Fiscal Year 2008 (continued)

MLN Matters Number: MM5898
Related Change Request (CR) Number: 5898
Related CR Release Date: February 22, 2008
Related CR Transmittal Number: R1459CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1459, CR 5898

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PROVIDER AUDIT ISSUES

REFINEMENTS IN COST REPORTING FOR RECALIBRATING DRG RELATIVE WEIGHTS UNDER THE INPATIENT PROSPECTIVE PAYMENT SYSTEM

A. BACKGROUND

In the fiscal year (FY) 2007 final rule (71 FR 47882), the Centers for Medicare & Medicaid Services (CMS) began to implement significant revisions to Medicare inpatient hospital rates by basing the relative weights on hospitals' estimated costs rather than on charges. The Medicare provider and review (MedPAR) files and the Medicare cost report are the data sources utilized to develop the cost based weights.

Some industry groups have expressed concerns about potential bias in cost weights due to "charge compression," which is the practice of applying a lower percentage markup to higher cost services and a higher percentage markup to lower cost services. There is concern that cost-based weights may undervalue high cost items and overvalue low cost items if a single cost-to-charge ratio (CCR) is applied to items of widely varying costs in the same cost center (e.g., for medical supplies and devices).

CMS commissioned RTI International (RTI) to conduct a study on charge compression. The RTI's draft interim report was posted in March 2007 on the CMS Web site at *https://cms.hhs.gov/reports/downloads/Dalton.pdf.*

The RTI report made several recommendations, including a short-term recommendation to expand the number of distinct hospital department CCRs from 13 to 19.

In the FY 2008 inpatient prospective payment system (IPPS) proposed rule (72 FR 24712), CMS did not propose to implement RTI's short-term recommendation for FY 2008 to expand the number of national CCRs from 13 to 19, although CMS solicited public comments on this issue. After considering the public comments, CMS added two national CCRs for a total of 15 CCRs.

The comments received on the proposed rule from several hospital and medical associations included recommendations on how the impact of charge compression might be mitigated through improvement in cost reporting by hospitals. A workgroup convened by the American Hospital Association, the Association of American Medical Colleges, and the Federation of American Hospitals found that CMS groupings of hospital charges on MedPAR differ from how hospitals group Medicare charges, total charges, and overall costs on their cost reports. This mismatch between MedPAR charges and cost report CCRs can distort diagnosis-related group (DRG) weights. For example, the workgroup found that reporting of chargeable medical supplies costs and charges on the cost report (line 55 of Worksheets C, Part I and D-4) to be a significant problem area because some hospitals report chargeable medical supply charges and costs in various ancillary departments on the cost reports, but report those charges on the medical supplies revenue code on the claim.

These hospital/medical associations have launched an educational campaign to encourage hospitals to report costs and charges, particularly for supplies, in a way that is consistent with the way that charges are grouped in MedPAR. Their suggestions include that hospitals should adopt an approach of classifying all billable medical supply costs and charges to line 55 of the cost report and mapping the 27x revenue summary codes from the Provider Statistical and Reimbursement Report (PS&R) only to line 55.

Therefore, the purpose of this change report is to inform the fiscal intermediaries and Medicare administrative contractors of the hospital/medical associations' initiative on encouraging hospitals to modify their cost reporting practices with respect to costs and charges, in an effort to improve the consistency of the cost-based IPPS DRG relative weights. CMS agrees that it would be beneficial for hospitals to consistently report costs and charges in their appropriate cost centers, and in a manner that is consistent with the way in which charges are grouped in MedPAR.

B. POLICY

The *Provider Reimbursement Manual* (PRM), Part I, section 2202.4 requires that costs and charges for a given service be matched and placed in the same cost center. Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Furthermore, it states that charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. Transmittal 18 of the hospital cost report will reaffirm this policy through the instruction in section 3620 for Worksheet C, on which charge ratios are calculated.

Section 2203 of the PRM I states that in order to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reporting, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.

Refinements in Cost Reporting for Recalibrating DRG Relative Weights Under the IPPS (continued)

C. Reporting and Review

Providers may submit cost reports with cost and charges grouped differently than in prior years, so long as the cost and charges are properly matched and Medicare cost reporting instructions are followed. Medicare contractors shall not propose adjustments that regroup costs and charges merely to be consistent with previous year's reporting if the costs and charges are properly grouped on the as-filed cost report. In addition, prior approval from the Medicare contractor is not needed to regroup billable medical supply costs and charges to lines 55 because this is not a change in cost finding methodology. Medicare contractors shall be vigilant to ensure that the costs of items and services are not moved from one cost center to another without moving the corresponding charges. Contractors shall use the applicable desk review thresholds to determine whether a limited or a full desk review needs to be performed on the as-filed cost reports. Contractors shall determine the level of review needed to resolve any material variance noted during the completion of the ADR section of the full desk review. If the contractor suspects that the cost-to-charge ratio reported for any cost center is unreasonable, the contractors can add steps to the limited desk review program to ensure proper matching of cost and charges. ❖

Source: CMS Pub. 100-20, Transmittal 321, CR 5928

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HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

JANUARY 2008 UPDATE OF THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article is based on change request (CR) 5946, which describes updates to both the *Medicare Claims Processing Manual* and the *Medicare Benefits Policy Manual* in order to clarify existing Centers for Medicare & Medicaid Services (CMS) outpatient prospective payment system (OPPS) policy. Much of this information has been conveyed previously by CR 5912, which is discussed in *MLN Matters* article MM5912 on the CMS Web site at *http://ww.cms.hhs.gov/MLNMattersArticles/downloads/MM5912.pdf*.

BACKGROUND

This article is based on CR 5946, which is quite lengthy and includes important changes regarding certain OPPS issues. Those details will not be repeated in this article, but they are available in CR 5946 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R82BP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1445CP.pdf*.

Many of the changes to the *Medicare Claims Processing Manua*l are being made simply to manualize changes already conveyed by CR 5912, which is summarized by *MLN Matters* article MM5912 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5912.pdf*.

The changes to both manuals are summarized in the remainder of this article.

MEDICARE CLAIMS PROCESSING MANUAL UPDATES

Key changes to this manual are summarized as follows:

Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 10

This section was modified to identify the five (5) composite ambulatory classification payments (APCs) that are effective for services furnished on or after January 1, 2008 in the following table:

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of *CPT* code *93619* or *93620* and at least one unit of *CPT* code *93650*, *93651* or *93652* on the same date of service
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of *CPT* codes 55875 and *77778* on the same date of service
8002	Level I Extended Assessment and Management Composite	1. Eight or more units of Healthcare Common Procedure Coding System (HCPCS) code G0378 are billed: • On the same day as HCPCS code G0379*; or • On the same day or the day after *CPT* codes *99205* or *99215.* 2. There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378.
8003	Level II Extended Assessment and Management Composite	1. Eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after 99284, 99285 or 99291. 2. There is no service with SI=T on the claim on the same date of service or 1 day earlier.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0033. For the list of mental health services to which this composite applies, see the integrated outpatient code editor (IOCE) supporting files for the pertinent period.

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

* Payment for direct admission to observation care (HCPCS code G0379) is made either under APC 604 (Level 1 hospital clinic visits) or APC 8002 (Level I extended management and assessment composite) or is packaged into payment for other separately payable services. See section 290.5.2 for additional information and the criteria for payment of HCPCS code G0379.
** For additional reporting requirements for observation services reported with HCPCS code G0378, see section 290.5.1 of this chapter.

Note: See addendum A on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* for the national unadjusted payment rates for these composite APCs.

Other changes were made to chapter 4, section 10, to:

- Further explain the calculation of APC payment rates.
- Emphasize the importance of reporting all HCPCS codes and all charges for all services because of the packaging of certain items and services under the OPPS.
- Explain the combinations of packaged services of different types that are furnished on the same date of service.
- Further clarify outlier adjustments.

Chapter 4, Section 20.5.1.1 – Packaged Revenue Codes

The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services (with new revenue codes bolded and italicized) are:

0250	0251	0252	0254	0255	0257	0258
0259	0260	0262	0263	0264	0269	0270
0271	0272	***0273***	0275	0276	0278	0279
0280	0289	***0343***	***0344***	0370	0371	0372
0379	0390	0399	0560	0569	0621	0622
0624	0630	0631	0632	0633	0681	0682
0683	0684	0689	0700	***0709***	0710	***0719***
0720	0721	***0732***	0762	***0801***	***0802***	***0803***
0804	***0809***	0810	0819	***0821***	***0824***	***0825***
0829	0942.					

Chapter 4, Section 20.5.1.4 – Revenue Codes for "Sometimes Therapy" Services

This section was added to show that certain wound care services described by *CPT* codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care.

Hospitals receive separate payment under the OPPS when they bill for certain wound care services that are furnished to hospital outpatients independent of a certified therapy plan of care.

When billing for wound care services under the OPPS that are furnished independent of a certified plan of care, providers should neither attach a therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech language pathology) to the wound care *CPT* codes nor report their charges under a therapy revenue code (that is, 042x, 043x, or 044x), to receive payment under the OPPS.

Chapter 4, Section 61.4 – Billing and Payment for Brachytherapy Sources

This new section contains information regarding billing for brachtherapy sources (e.g. brachytherapy devices or seeds, solutions), which are paid separately from services to administer and deliver brachytherapy in the OOPS, per section 1833 T)(2)(H) of the Social Security Act. This payment for brachytherapy sources reflects the number, isotope, and radioactive intensity of devices furnished, as well as stranded versus non-stranded configuration of sources.

The list of separately payable sources is found in addendum B of the most recent OPPS annual update published in the *Federal Register*, as well as in the recurring update notifications of the current year for billing purposes. (See addendum B on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/.*) New sources meeting the OPPS definition of a brachytherapy source may be added for payment beginning any quarter, and the new source codes and descriptors are announced in the recurring update notifications.

Each unit of a billable source is identified by the unit measurement in the respective source's long descriptor. Seed-like sources are generally billed and paid "per source" based on the number of units of the source HCPCS code reported, including the billing of the number of sources within a stranded configuration of sources. Providers therefore must bill the number of units of a source used with the brachytherapy service rendered.

Brachytherapy sources eligible for separate billing and payment must be radioactive sources, meaning that the source contains a radioactive isotope. Separate brachytherapy source payments reflect the number, isotope, and radioactive intensity of sources furnished to patients, as well as stranded and non-stranded configurations.

A hospital may report and charge Medicare and the Medicare beneficiary for all brachytherapy sources that are ordered by the physician for a specific patient, acquired by the hospital, and used in the care of the patient. Specifically, brachytherapy sources prescribed by the physician in accordance with high quality clinical care, acquired by the hospital, and actually implanted in the patient may be reported and charged. In the case where most, but not all, prescribed sources are implanted in the patient, CMS will consider the relatively few brachytherapy sources that were ordered but not implanted due to specific clinical considerations to be used in the care of the patient and billable to Medicare under the following circumstances. The hospital may charge for all sources if they were specifically acquired by the hospital for the particular patient according to a physician's prescription for the sources that was consistent with standard clinical practice and high quality brachytherapy treatment, in order to ensure that the clinically appropriate number of sources was available for the implantation procedure, and they were not implanted in any other patient. Those sources that were not implanted must have been disposed of in accordance with all appropriate requirements for their handling. In general, the number of sources used in the care of the patient but not implanted would not be

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

expected to constitute more than a small fraction of the sources actually implanted in the patient. Under these circumstances, the beneficiary is liable for the copayment for all the sources billed to Medicare.

Providers should report charges related to supervision, handling, and loading of radiation sources, including brachytherapy sources, in one of two ways:

- Report the charge separately using *CPT* code *77790* (*Supervision, handling, loading of radiation source*), in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source; or
- Include the supervision, handling, and/or loading charges as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source.

Do not bill a separate charge for brachytherapy source storage costs. These costs are treated as part of the department's overhead costs.

Chapter 4, Section 200.4 Billing for Amniotic Membrane

This section was added to show that hospitals should report HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to report amniotic membrane tissue when the tissue is used. A specific procedure code associated with use of amniotic membrane tissue is *CPT* code *65780* (*Ocular surface reconstruction; amniotic membrane transplantation*). Payment for the amniotic membrane tissue is packaged into payment for *CPT* code *65780* or other procedures with which the amniotic membrane is used.

Chapter 4, Section 200.5 – Billing and Payment for Cardiac Rehabilitation Services

This section was added to reflect the national coverage determination for cardiac rehabilitation programs, which requires that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. See the *National Coverage Determination (NCD) Manual*, section 20.10, for more information. (This manual is available on the CMS Web site at *http://www.cms.gov/Manuals/IOM/list.asp*.)

A cardiac rehabilitation session may include more than one aspect of the comprehensive program. For CY 2008, hospitals will continue to use *CPT* code *93797* (*Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)*) and *CPT* code *93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)*) to report cardiac rehabilitation services. However, effective for dates of service on or after January 1, 2008, hospitals may report more than one unit of *CPT* code *93797* or *97398* for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the cardiac rehabilitation services provided on a given day total one hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

Chapter 4, Section 200.6 – Billing and Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening and intervention services. They are CPT code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). However, screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, beginning January 1, 2008, the OPPS recognizes two parallel G-codes (HCPCS codes G0396 and G0397) to allow for appropriate reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury.

Contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance(other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes), only when reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Act.

HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. Hospital resources expended performing services described by HCPCS codes G0396 and G0397 may not be counted as resources for determining the level of a visit service and vice versa (i.e., hospitals may not double count the same facility resources in order to reach a higher level clinic or emergency department visit). However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPCS codes, but the hospital resources expended should be included in determining the level of the visit service reported.

Chapter 4, Section 200.7.1 Cardiac Echocardiography Without Contrast

This section instructs hospitals to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

Chapter 4, Section 200.7.2 Cardiac Echocardiography With Contrast

This section instructs hospitals to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 200.7.2 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms.

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

200.7.2 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	Long Descriptor
C8921	Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; complete
C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study
C8925	Transesophageal echocardiography (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
C8926	Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	Transesophageal echocardiography (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	Transthoracic echocardiography with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

Chapter 4, Section 200.8 – Billing for Nuclear Medicine Procedures

Effective January 1, 2008, the I/OCE will begin editing for the presence of a diagnostic radiopharmaceutical HCPCS code when a separately payable nuclear medicine procedure is present on a claim. Hospitals should begin including diagnostic radiopharmaceutical HCPCS codes on the same claim as a nuclear medicine procedure beginning on January 1, 2008. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of service. More information regarding these edits is available at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* on the CMS Web site.

Chapter 4, Section 290, Subsections Dealing with Observation Services

These sections have been revised to add clarifications and updates related to the reporting hours of observation and billing and payment for observation. Note that general standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services. Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

Also, observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In certain circumstances when observation care is billed in conjunction with a high level clinic visit (Level 5), high level emergency department visit (Level 4 or 5), critical care services, or direct admission as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met. For information about payment for extended assessment and management composite APCs, see chapter 4, section 10.2.1 (Composite APCs) of the *Medicare Claims Processing Manual*.

APC 8002 (Level I extended assessment and management composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (8 or more hours). APC 8003 (Level II extended assessment and management composite) describes an encounter for care

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for payment of these composite APCs; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the PRICER, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time
   a. Observation time must be documented in the medical record.
   b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.
   c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
   d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.
2. Additional Hospital Services
   a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
      - An emergency department visit (*CPT* code *99284* or *99285*) or
      - A clinic visit (*CPT* code *99205* or *99215*); or
      - Critical care (*CPT* code *99291*); or
      - Direct admission to observation reported with HCPCS code G0379 (APC 0604) must be reported on the same date of service as the date reported for observation services.
   b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.
3. Physician Evaluation
   a) The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
   b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that observation services will be packaged or will meet the criteria for extended assessment and management composite payment.

Only observation services that are billed on a 13x bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct admission to observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in CR4047, Transmittal 763, issued on November 25, 2005. The *MLN Matters* article related to that CR is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4047.pdf*.

If a claim for services providing during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

Direct admission to observation care continues to be reported using HCPCS code G0379 (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct admission to observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community.

Payment for direct admission to observation will be made either separately as a low level hospital clinic visit under APC 0604 or packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite) or packaged into the payment for other separately payable services provided in the same encounter. The criteria for payment of HCPCS code G0379 under either APC 0604 or APC 8002 include:

- Both HCPCS codes G0378 (Hospital observation services, per hr) and G0379 (Direct admission of patient for hospital observation care) are reported with the same date of service; and.
- No service with a status indicator of T or V or critical care (APC 0617) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

packaged into payment for other separately payable services provided in the same encounter.

Only direct admission to observation services billed on a 13x bill type may be considered for a composite APC payment.

When services are not covered as observation services, hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPPS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the *Medicare Benefit Policy Manual*, chapter 6, section 20.6 for further explanation of noncovered services and notification of the beneficiary in relation to observation care. That manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Chapter 16, Section 40.3 – Hospital Billing Under Part B

This section was updated to include information related to billing certain Part B services. Specifically, if a hospital bills claims for both hospital outpatient and non-patient laboratory tests on different dates of service, it should prepare two bills: one for the outpatient (13x type of bill) laboratory test and the other for the nonpatient laboratory specimen (14x type of bill) tests. The hospital includes laboratory tests provided to hospital outpatients on the same bill with other hospital outpatient services to the same beneficiary, unless it is billing for non-patient laboratory specimen tests provided on a different day from the other hospital outpatient services, in which case it submits a separate bill for the non-patient laboratory specimen tests.

For all hospitals except critical access hospital (CAHs) and Maryland waiver hospitals, if a patient receives hospital outpatient services on the same day as a specimen collection and laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. However if the non-CAH or Maryland waiver hospital only collects or draws a specimen from the beneficiary and the beneficiary does not also receive hospital outpatient services on that day, the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non- patient on the 14x bill type.

For CAHs, payment for clinical diagnostic laboratory tests is made at 101 percent of reasonable cost only if the individuals are outpatients of the CAH (85x type of bill), as defined in 42 CFR 410.2, and are physically present in the CAH at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who are not physically present at the CAH (non-patients 14x type of bill) when the specimens are collected are made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act. See also 42 CFR 413.70(b)(iii). Similarly, for Maryland waiver hospitals, the waiver is limited to services to inpatients and registered outpatients as defined in 42 CFR 410.2. Therefore payment for nonpatient (specimen only, TOB 14x) who are not registered outpatients at the time of specimen collection will be made on the clinical diagnostic laboratory fee schedule.

Chapter 17, Section, 90.2 – Drugs, Biologicals, and Radiopharmaceuticals

This chapter was revised to include the following:

A. General Billing and Coding for Hospital Outpatient Drugs, Biologicals, and Radiopharmaceuticals

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

Payment for drugs, biologicals, and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost. Hospitals should include these costs in their line-item charges for drugs, biologicals, and radiopharmaceuticals.

Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

The HCPCS code list of retired codes and new HCPCS codes reported under the hospital OPPS is published quarterly via CRs that are known as recurring update notifications. The latest payment rates associated with each APC and HCPCS code may be found in the most current addendum A and addendum B, respectively, which may be found under the CMS quarterly provider updates on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp*.

B. Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision, which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. According to section 1833(t) of the Social Security Act, transitional pass-through payments can be made for at least 2 years, but no more than 3 years. To see the latest instructions and for the process and information required to apply for transitional pass-through payment status for drugs, biologicals, and radiopharmaceuticals, go to the main OPPS Web page on the CMS Web site, currently at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

Payment rates for pass-through drugs, biologicals, and radiopharmaceuticals are updated quarterly. The all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals for pass-through payment is included in the current quarterly Addendum B. The most current Addendum B can be found under the CMS quarterly provider updates on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp*.

C. Non Pass-Through Drugs and Biologicals

Under the OPPS, drugs and biologicals that are not granted pass-through status receive either packaged payment or separate payment. Payment for drugs and biologicals with estimated per day costs equal to or below the applicable drug-packaging threshold is packaged into the payment for the associated procedure, commonly a drug administration procedure. Drugs and biologicals with per day costs above the applicable drug-packaging threshold are paid separately through their own APCs.

D. Radiopharmaceuticals

1. General

Beginning in CY 2008, the OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function effectively as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Therapeutic radiopharmaceuticals are themselves the primary therapeutic modality.

2. Diagnostic Radiopharmaceuticals

Beginning in calendar year (CY) 2008, payment for non pass-through diagnostic radiopharmaceuticals is packaged into the payment for the associated nuclear medicine procedure.

Beginning January 1, 2008, the I/OCE will begin requiring claims with separately payable nuclear medicine procedures to include a diagnostic radiopharmaceutical. Hospitals are required to submit the diagnostic radiopharmaceutical on the same claim as the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of service. More information regarding these edits is available on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

3. Therapeutic Radiopharmaceuticals

The OPPS will continue to pay for non pass-through therapeutic radiopharmaceuticals at charges adjusted to cost From January 1, 2008 through June 30, 2008. Beginning July 1, 2008, payment for separately payable therapeutic radiopharmaceuticals under the OPPS will be made on a prospective basis with payment rates based upon mean costs from hospital claims data, unless otherwise required by law.

MEDICARE BENEFIT POLICY UPDATES

The key new/revised sections of **the Medicare Benefit Policy Manual** that are conveyed by in CR5946 are intended to clarify existing policy regarding the OPPS. Basically, these clarifications are in the following areas:

- Chapter 6 (Hospital Services Covered under Part B), section 20 (Outpatient Hospitals Services). The subsections that are new or revised include discussions on:
  - Limitations of coverage of certain services to hospital outpatients and an exception to the limitation.
  - Definitions of outpatient, encounter, and diagnostic services.
  - Outpatient diagnostic services.
  - Outpatient Therapeutic Services; and Outpatient observation services.
- Chapter 6, Section 70.5, which clarifies policy regarding laboratory services furnished to non- hospital patients by the hospital laboratory.

The actual revisions to this manual are available as an attachment to the CR5946, Transmittal R82BP, which is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R82BP.pdf*.

ADDITIONAL INFORMATION

The official instruction, CR 5946, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed by looking at two transmittals. The first transmittal has the changes to the *Medicare Claims Processing Manual* and is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1445CP.pdf*.

The second transmittal contains the changes to the *Medicare Benefit Policy Manual* and it is on the same site at *http://www.cms.hhs.gov/Transmittals/downloads/R82BP.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 1-888-664-4112.

MLN Matters Number: MM5946
Related Change Request (CR) Number: 5946
Related CR Release Date: February 8, 2008
Related CR Transmittal Number: R1445CP and R82BP
Effective Date: January 1, 2008
Implementation Date: March 10, 2008

Source: CMS Pub. 100-04, Transmittal 1445, CR 5946

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Electronic Data Interchange

Claim Status Category Code and Claim Status Code Update

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5947, which indicates there have been updates to the claim status category codes and claim status codes.

CAUTION – What You Need to Know

All code changes approved during the October 2007 meeting of the National Code Maintenance Committee have been posted at *http://www.wpc-edi.com/content/view/180/223/* and will become effective April 1, 2008.

GO – What You Need to Do

See the *Background* section for further details.

Background

The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers, including Medicare, to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee. These codes are used in the X12 276/277 health care claim status request and response format to explain the status of submitted claim(s).

The decisions about additions, modifications, and retirement of existing claim status category and claim status codes made at the October 2007 meeting of the national Code Maintenance Committee were posted at *http://www.wpc-edi.com/content/view/180/223/* on November 5, 2007. These updates are effective April 1, 2008 and are to be used in editing of all X12 276 transactions processed by Medicare contractors on or after April 7, 2008.

Additional Information

To see the official instruction (CR 5947) issued to your Medicare FI, carrier, DME MAC, or A/B MAC, refer to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1468CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-888-664-4112.

MLN Matters Number: MM5947
Related Change Request (CR) Number: 5947
Related CR Release Date: February 29, 2008
Related CR Transmittal Number: R1468CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1468, CR 5947

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Healthcare Provider Taxonomy Code Update Effective April 1, 2008

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

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

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

Source: CMS Pub. 100-04, Transmittal 1462, CR 5951

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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], durable medical equipment Medicare administrative contractors [DME MACs]) for services.

PROVIDER ACTION NEEDED

Change request (CR) 5942, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective April 1, 2008. Be sure billing staff 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 some coordination-of-benefits (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 at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5942.

CMS has also developed a new tool to help you search for a specific category of code and that tool is available on the Internet at *http://www.cmsremarkcodes.info*.

Note: 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 5942) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1475CP.pdf*.

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 1-888-664-4112.

REMITTANCE ADVICE REMARK CODE CHANGES

New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 *Note: (New Code 11/5/07)*	YES
N431	Service is not covered with this procedure. Start: 11/5/2007 *Note: (New Code 11/5/07)*	YES
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 *Note: (New Code 11/5/07)*	YES

Modified Codes

Code	Current Modified Narrative	Last Modification Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	11/5/2007

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Code	Current Modified Narrative	Last Modification Date
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	11/5/2007
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies.	11/5/2007
N367	**Alert:** The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 | Stop: 5/1/2008 | Last Modified: 11/5/2007 *Note: (Deactivated effective 5/1/08) Consider using Reason Code B4.*)	Deactivated effective 5/1/08

CLAIM ADJUSTMENT REASON CODES

New Codes

Code	Current Narrative	Implementation Date
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Modified Codes

Code	Modified Narrative	Implementation Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
192	Non-standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier – Invalid format Start: 07/09/2007 | Stop: 05/23/2008 | Last Modified: 09/30/2007	4/1/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Code	Modified Narrative	Implementation Date
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed `proven to be effective' by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
129	Prior processing information appears incorrect. Start: 02/28/1997 | Last Modified: 09/30/2007	4/1/2008

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Code	Modified Narrative	Implementation Date
135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007	4/1/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007	4/1/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Code	Modified Narrative	Implementation Date
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B16	`New Patient' qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

Deactivated Codes

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008	4/1/2008
126	Deductible – Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Stop: 04/01/2008 | Last Modified: 09/30/2007	4/1/2008

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

MLN Matters Number: MM5942
Related Change Request (CR) Number: 5942
Related CR Release Date: March7, 2008
Related CR Transmittal Number: R1475CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1475, CR 5942

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EDUCATIONAL EVENTS

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

MAY 2008 – JULY 2008

2008 Medicare Symposium

When: Tuesday & Wednesday, May 6 & 7, 2008

Where: Marriot Orlando Downtown
400 West Livingston Street, Orlando, FL 32801
1-407-843-6664

Type of Event: In Person Seminar

Hot Topics – Medicare Updates

When: Tuesday, May 13, 2008

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

Type of Event: Teleconference

Hot Topics – Medicare Updates

When: Tuesday, July 15, 2008

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

Type of Event: Teleconference

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

MARCH IS NATIONAL NUTRITION MONTH

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. Approximately 8.6 million Americans[1] at least 60 years or older are diagnosed with diabetes or acute renal failure. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

MEDICARE COVERAGE

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) when provided by a registered dietitian or nutrition professional who meets the provider qualification requirements. The beneficiary's treating physician must provide a referral and indicate a diagnosis of diabetes or renal disease. Medicare provides coverage for three hours of MNT in the first year and two hours in subsequent years. Additional hours may be covered in certain situations.

Note: For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [glomerular filtration rate (GFR) 13-50 ml/min/1.73m2].

HELP US SPREAD THE WORD

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS needs your help to ensure that all eligible people with Medicare are aware of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

FOR MORE INFORMATION

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

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

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

- **Diabetes-Related Services Brochure** – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes.

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

  To order copies of the brochure, go to the *MLN* Product Ordering System located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

- CMS Web site provides additional information about the MNT benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy/.*

  For information to share with your Medicare patients, visit *http://www.medicare.gov*.

  For more information about National Nutrition Month®, please visit *http://www.eatright.org*.

Thank you for your support in helping CMS spread the word about the benefits of good nutrition, healthful eating and the medical nutrition therapy benefit covered by Medicare that may help people with Medicare learn to control and manage their medical conditions. ❖

[1]The United States Renal Data System and National Diabetes Information Clearinghouse *http://diabetes.niddk.nih.gov/dm/pubs/statistics*.

Source: CMS Provider Education Resource 200803-05

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.*

MARCH IS NATIONAL COLORECTAL CANCER AWARENESS MONTH

The goal of this national health observance is to increase awareness that colorectal cancer is largely preventable, treatable and beatable. In conjunction with National Colorectal Cancer Awareness Month, the Centers for Medicare & Medicaid Services (CMS) remind health care professionals that Medicare provides coverage for certain colorectal cancer screenings. Colorectal cancer affects both men and women of all racial and ethnic groups, and is most often found in people aged 50 years or older. And the risk for developing colorectal cancer increases with age.

MEDICARE COVERED COLORECTAL CANCER SCREENINGS

Medicare provides coverage of colorectal cancer screenings for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of the screening colonoscopy. An individual is considered to be at high risk for colorectal cancer if he or she has:

- had colorectal cancer before
- a history of polyps
- a family member who has had colorectal cancer or a history of polyps
- a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Medicare provides coverage for the following colorectal cancer screenings subject to certain coverage, frequency, and payment limitations:

- Fecal occult blood test (FOBT)
- Colonoscopy
- Sigmoidoscopy
- Barium enema (as an alternative to a covered screening flexible sigmoidoscopy or screening colonoscopy)

PREVENTION IS KEY

Colorectal cancer is the second leading cancer killer in the United States; however it doesn't have to be. Colorectal cancer is largely preventable through screening which can find precancerous polyps-abnormal growths in the colon or rectum-so that they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage, when treatment can often lead to a cure. CMS needs your help to ensure that eligible Medicare patients get screened for colorectal cancer. Talk with your Medicare patients and their caregivers about the importance of being screened and those patients who were screened before entering Medicare should be encouraged to continue with screening at clinically appropriate intervals.

FOR MORE INFORMATION

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The *MLN* Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff.
  http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.
- Cancer Screenings Brochure – This tri-fold brochure provides health care professionals with an overview of cancer screenings covered by Medicare, including colorectal cancer screening services.
  http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf.

  To order copies of the brochure, go to the *MLN* Product Ordering Page located at
  http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

  For information to share with your Medicare patients, visit *http://www.medicare.gov*.

  For more information about National Colorectal Cancer Awareness Month, please visit
  http://www.preventcancer.org/colorectal3c.aspx?id=1036.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives. Thank you. ❖

Source: CMS Provider Education Resource 200803-08

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.*

OTHER EDUCATIONAL RESOURCES

ACUTE INPATIENT PROSPECTIVE PAYMENT SYSTEM FACT SHEET NOW AVAILABLE

The revised *Acute Inpatient Prospective Payment System Fact Sheet* (November 2007), which provides general information about the acute inpatient prospective payment system (IPPS) and how IPPS rates are set, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network.* To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS Provider Education Resource 200803-09

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FACT SHEET NOW AVAILABLE

The *Hospital Outpatient Prospective Payment System Fact Sheet* (revised January 2008), which provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/* scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS Provider Education Resource 200803-04

THE MEDICARE APPEALS PROCESS—FIVE LEVELS TO PROTECT PROVIDERS

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers brochure has been updated and is now available to order print copies or as a downloadable PDF file. To view the PDF file, go to *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf* or to order hard copies, please visit the MLN Product Ordering Page on the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. ❖

Source: CMS Provider Education Resource 200803-01

AMBULANCE FEE SCHEDULE FACT SHEET NOW AVAILABLE

The *Ambulance Fee Schedule Fact Sheet*, which provides general information about the ambulance fee schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf*. ❖

Source: CMS Provider Education Resource 200802-15

INFORMATIONAL DVD AVAILABLE FOR INDIAN HEALTH PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) is making the following DVD available for Indian Health providers: Our Health, Our Community: Medicare, Medicaid and SCHIP outreach to American Indians/Alaskan Natives is a brief informational DVD on the benefits of enrolling in Medicare, Medicaid and SCHIP for the American Indian/Alaskan Native audience.

This DVD may be used in hospital, clinic, and physician office waiting rooms, local TV stations, exhibits, training events, or any place American Indians and Alaskan Natives are gathered. (ICN# 6940) (Dec 2007). Run time is 7 minutes, 51 seconds. This product is only for those providers that serve the American Indian and Alaskan Native populations.

To order a free copy, go to the Medicare Learning Network MLN Product Ordering Page *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* and select the DVD title from the product list. ❖

Source: CMS Provider Education Resource 200803-05

AMBULATORY SURGICAL CENTER FEE SCHEDULE FACT SHEET NOW AVAILABLE

The *Ambulatory Surgical Center Fee Schedule Fact Sheet*, which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit http://www.cms.hhs.gov/mlngeninfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS Provider Education Resource 200803-06

HOSPICE PAYMENT SYSTEM FACT SHEET NOW AVAILABLE

The revised *Hospice Payment System Fact Sheet* (December 2007), which offers providers information about the Medicare hospice benefit, 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."

If your URL does not take you directly to the fact sheet, please copy and paste the URL in your Web browser. ❖

VISIT THE MEDICARE LEARNING NETWORK – IT'S FREE

Source: CMS Provider Education Resource 200802-19

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 Medicare Providers Florida Part A or B, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

ORDER FORM – PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: FCSO – account number 700284).

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

Important Address, Telephones Numbers and Web Sites

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

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

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

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

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦