MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Routing Suggestions :

- ☐ **Medicare Manager**
- ☐ **Reimbursement Director**
- ☐ **Chief Financial Officer**
- ☐ **Compliance Officer**
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The *Medicare A Bulletin* is published monthly by First Coast Service Options, Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers in Florida.

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

Medicare Publications
1-904-361-0723

ABOUT THE *MEDICARE A BULLETIN*

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

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

WHO RECEIVES THE *BULLETIN*?

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

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

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

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

WHAT IS IN THE *BULLETIN*?

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

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

THE MEDICARE A BULLETIN REPRESENTS FORMAL NOTICE OF COVERAGE POLICIES

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

Do You Have Comments?

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

Medicare Publications
1-904-361-0723

QUARTERLY PROVIDER UPDATE

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

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

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

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

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

GENERAL INFORMATION

CLARIFICATION OF MEDICARE BAD DEBT POLICY RELATED TO ACCOUNTS AT A COLLECTION AGENCY

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

PROVIDER TYPES AFFECTED

All fee for service hospital and non-hospital providers who bill Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) and are eligible to claim bad debt for Medicare beneficiaries.

PROVIDER ACTION NEEDED

In order for providers to properly claim a bad debt and be reimbursed under the Medicare program, providers must follow all of the *Criteria for Allowable Bad Debt* set out at 42 C.F.R. section 413.89(e). See *http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html* on the Internet and sections 308 and 310 of *the Provider Reimbursement Manual* (CMS Publication 15-1) available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/PBM/list.asp*.

Pursuant to those criteria, a provider must establish that reasonable collection efforts were made. A provider must establish that the debt is uncollectible when claimed as worthless and use sound business judgment to your billing staff is aware of this information.

BACKGROUND

It has been the Centers for Medicare & Medicaid Services (CMS) longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations found at 413.89(e). See 31 FR 14813; published November 22, 1966), and in chapter 3 of the *Provider Reimbursement Manual* (PRM). Section 310.A of the PRM explicitly states that "A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts."

Until a provider's reasonable collection effort (including the use of a collection agency as well as in-house efforts) has been completed, a Medicare bad debt may not be deemed as uncollectible. Section 310.2 of the PRM, Presumption of Noncollectibilitiy, provides that, "If after reasonable and customary attempts to collect a bill, the debt remains unpaid for more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible." However, section 310.2 must be read within the context of the regulations and section 310. As noted above, the manual makes it clear that CMS deems the use of a collection agency to be part of the provider's ongoing collection effort, and as long as the debt remains with a collection agency (even if more than 120 days), the debt cannot be deemed "uncollectible." Therefore, in accordance with the regulation/policy in effect prior to the moratorium, effective August 1, 1987, until a provider's reasonable collection efforts have been completed, including both in-house efforts and the use of a collection agency, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare bad debt.

ADDITIONAL INFORMATION

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: SE0824
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 SE0824

REMINDER—MEDICARE PROVIDES COVERAGE OF DIABETES SCREENING TESTS

The Centers for Medicare & Medicaid Services (CMS) has released special edition *MLN Matters* article SE0821 titled "Reminder – Medicare Provides Coverage of Diabetes Screening Tests" located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0821.pdf*.

This article reminds health care professionals that Medicare pays for diabetes screening tests for eligible beneficiaries and provides the correct procedure and diagnosis codes and modifier to use when filing claims for this screening service. ❖

Source: CMS Provider Education Resource 200807-02

WAIVING RETROACTIVE BENEFICIARY COST SHARING DUE TO INCREASED PAYMENT RATES

The United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to *http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF*. ❖

Source: CMS Provider Education Resource 200807-28

CMS PILOT PROGRAM SAVING NEARLY $700 MILLION IN IMPROPER MEDICARE PAYMENTS

The Centers for Medicare & Medicaid Services (CMS) today released a new report offering fresh evidence that the recovery audit contractors (RACs) pilot program is successfully identifying improper payments. The findings will also help the agency improve the program as it is expanded nationwide within two years, officials say.

The evaluation report shows that $693.6 million in improper Medicare payments was returned to the Medicare trust funds between 2005 and March 2008. The funds returned to the Medicare trust funds occurred after taking into account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

To view the entire press release, please click: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

To view the RAC Evaluation Report: *http://www.cms.hhs.gov/RAC*. ❖

Source: CMS Provider Education Resource 200807-14

NOTICE OF INTEREST RATE FOR MEDICARE OVERPAYMENTS AND UNDERPAYMENTS

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

The Department of the Treasury has notified the Department of Health & Human Services that the PCR has been changed to **11.125 percent**, **effective July 24, 2008.** The PCR will remain in effect until a new rate change is published. Below is a list of previous interest rates.

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

Source: CMS Pub. 100-06, Transmittal 140, CR 5751

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008— IMPORTANT INFORMATION ON THE NEW MEDICARE LAW

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

This article contains a compilation of messages that were issued on July 16, 2008.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. This legislation alters a number of Medicare policies that have been the subject of a number of change requests (CRs) and *MLN Matters* articles published in recent months. The Centers for Medicare & Medicaid Services (CMS) is in the process of revising these previously issued CRs and *MLN Matters* articles as a result of this legislation. However, CMS feels it is important that physicians, providers and suppliers be aware of five critical issues immediately.

These five issues are:

- New 2008 Medicare physician fee schedule (MPFS) payment rates effective for dates of service July 1, 2008, through December 31, 2008.
- Extension of the exceptions process for the therapy caps.
- A delay in the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program.
- Reinstatement of the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients.
- Extension of the payment rule for brachytherapy and therapeutic radiopharmaceuticals.

Be sure your billing staff is aware of these changes.

BACKGROUND

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. While MIPPA calls for numerous changes to the Medicare program, this special edition article covers five key provisions as noted above.

1. New 2008 Medicare Physician Fee Schedule Payment Rates Effective for Dates of Service July 1, 2008, Through December 31, 2008

As a result of this legislation, the mid-year 2008 MPFS rate of 10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, nonphysician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 percent update rates in approximately 10 business days, or less, for claims with dates of service on or after July 1, 2008. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, nonphysician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims with dates of service on or after July 1, 2008, that have been on hold. These claims will be processed on a rolling basis (first in/first out) for payment at the 10.6 percent update level. After your Medicare contractor begins to pay claims at the new 0.5 percent rate, to the extent lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Nonparticipating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Medicare contractor websites are being updated with the new rates and these should be available shortly. Be aware that any published *MLN Matters* articles affected by the new law will be revised or rescinded as appropriate.

2. Extension of Therapy Cap Exceptions

Another key provision of the MIPPA legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with modifier **KX** for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report modifier **KX** will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit modifier **KX** on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without modifier **KX** that would qualify for an exception. Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit

Medicare Improvements for Patients and Providers Act of 2008—Information on the New Medicare Law (continued)

these claims appending modifier **KX** so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.
In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

3. Delay in the DMEPOS Competitive Bidding Program

This new law also has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program. Items that had been included in the first round of the DMEPOS competitive bidding program may be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding the new law's impact on this program will be forthcoming.

4. Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the MPFS for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, Medicare contractors have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.
The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), section 104, expired on June 30, 2008. A new extension of the moratorium has been established by section 136 of MIPPA, retroactive to July 1, 2008.
A previous communication (*MLN Matters* article MM6088) indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

5. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

MIPPA extends the use of the cost to charge payment methodology for brachytherapy and therapeutic radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the outpatient prospective payment system (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing of affected claims will be complete by September 30, 2008.

ADDITIONAL INFORMATION

Be on the alert for more information about other legislative provisions, which may affect you.

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.

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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 SE0826

2008 MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare physician fee schedule (MPFS) rate of 10.6 percent has been replaced with a 0.5 percent update, retroactive to July 1, 2008.

Physicians, nonphysician practitioners, and other providers of services paid under the MPFS should begin to receive payment at the 0.5 percent update rates in approximately 10 business days, or less. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, nonphysician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims that have been on hold on a rolling basis (first in/first out) for payment at the 10.6 percent update level. After your local contractor begins to pay claims at the new 0.5 percent rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later, billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount, will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Nonparticipating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Contractor Web sites are being updated with the new rates and these should be available shortly. Be aware that any published *MLN Matters* articles affected by the new law will be revised or rescinded as appropriate.

Finally, be on the alert for more information about other legislative provisions, which may affect you.

Further instructions regarding other provisions of MIPPA will be forthcoming. ❖

Source: CMS Provider Education Resource 200807-17
CMS Provider Education Resource 200807-18
CMS JSM 08410, July 16, 2008

HOLDING OF CLAIMS PAID UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

The questions and answers below apply to the recent decision by the Centers for Medicare & Medicare Services to hold claims paid under the Medicare physician fee schedule (MPFS) up to 10 business days that contain July 2008 dates of service.

Q1. Will claims containing services paid under the MPFS be held that contain both June and July dates of service?

A1. Yes, your local contractor will hold the entire claim for 10 business days.

Q2. Will claims be held that contain both services paid under the MPFS and services paid under a separate fee schedule?

A2. Yes, claims that contain both services paid and not paid under the MPFS will be held. For example, a claim with a July date containing an evaluation and management code and a drug code would be held.

Q3. Does the holding of claims paid under the MPFS also include anesthesia and purchased diagnostic services?

A3. Yes, contractors will hold all claims with dates of service July 1, 2008, and after that contain services paid under the MPFS, including anesthesia and purchased diagnostic services. ❖

Source: CMS Provider Education Resource 200807-04

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.

REVISED FEES FOR SELECTED MENTAL HEALTH SERVICES

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare physician fee schedule rate of 10.6 percent has been replaced with a 0.5 percent update, retroactive to July 1, 2008.

In addition, fees have been revised for selected mental health codes, effective for dates of service on and after July 1, 2008, through December 31, 2008.

Note: The fees listed below do not apply for dates of service January 1, 2008, through June 30, 2008.

***CPT* Code**	**Locality 01/02**	**Locality 03**	**Locality 04**
90804	$64.06	$66.02	$68.06
90805	$70.78	$72.83	$74.93
90806	$90.83	$93.22	$95.74
90807	$100.39	$103.22	$106.24
90808	$134.18	$137.62	$141.29
90809	$143.00	$146.82	$150.93
90810	$68.26	$70.41	$72.73
90811	$78.35	$80.83	$83.41
90812	$98.54	$101.24	$104.00
90813	$108.14	$111.24	$114.47
90814	$141.15	$144.84	$148.70
90815	$149.97	$154.04	$158.34

Source: CMS JSM 08410, July 16, 2008

AMBULANCE SERVICES

INCREASED PAYMENT FOR GROUND AMBULANCE SERVICES UNDER MIPPA

The Centers for Medicare & Medicaid Services will soon be issuing formal contractor instructions that will incorporate the information contained in this announcement.

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

The increase will be effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. Specifically,

- For covered ground ambulance transports which originate in a rural area, the fee schedule amounts are increased by **three** percent.
- For covered ground ambulance transports which originate in a non-rural area, the fee schedule amounts are increased by **two** percent.

Contractors have been instructed to hold all ambulance claims affected by these changes, and release them for processing upon implementation of the revised fee schedule files. Contractors have also been instructed to identify and, to the extent possible, automatically reprocess any claims that were paid under the pre-MIPPA fee schedule rates and to complete that reprocessing no later than September 30, 2008. There will, however, be some claims that cannot be automatically adjusted (e.g., the charge submitted with the initial claim was below the new fee schedule amount). Ambulance providers should contact their claim processing contractor for guidance on obtaining an adjustment of these claims.

In addition MIPAA Section 146(b)(1) makes changes for certain air ambulance services provided July 1, 2008 – December 31, 2009. CMS will be issuing guidance to contractors on how to implement these changes and will send out another listserv message when additional information is available on this provision. ❖

Source: CMS Provider Education Resource 200807-28

DMEPOS COMPETITIVE BIDDING PROGRAM

DELAY OF THE MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program. Items that had been included in the first round of the DMEPOS competitive bidding program may be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding this new law will be forthcoming. ❖

Source: CMS Provider Education Resource 200807-21

ACCREDITATION DEADLINES FOR DMEPOS COMPETITIVE BIDDING CANCELLED

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program.

As a result of this delay, the special accreditation deadlines previously established for the second round of the program have been cancelled. Specifically, prior to enactment of this new law, suppliers must have been accredited or have applied for accreditation by July 21, 2008, to be eligible to submit a bid for the second round of competitive bidding and must have obtained accreditation by January 14, 2009, to be eligible for a second round contract. Both of these deadlines have been cancelled and no longer apply.

The deadline of September 30, 2009, that was previously established by which all DMEPOS suppliers must be accredited is still in effect. ❖

Source: CMS Provider Education Resource 200807-25

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM NEWS

OMBUDSMAN PROGRAM

The Ombudsmen for the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program are now available to assist providers, suppliers, and beneficiaries by providing information and education and by facilitating the resolution of complaints and concerns. The ombudsmens' role is to investigate and address complaints by providers, suppliers, and beneficiaries specifically related to the competitive bidding program. There are eight ombudsmen who are located within the initial competitive bidding areas (CBAs).

You may contact an ombudsman:

- For general information about the DMEPOS Competitive Bidding program
- To obtain assistance in locating a contract supplier
- For educational programs and activities
- To report concerns about the program, a supplier, or a referral agent
- The quality of services or items, and/or suspected fraud or abuse
- For assistance with questions, issues, and complaints specifically pertaining to the competitive bidding program and policies.

You may find a list of the ombudsmen with contact information on the DMEPOS Competitive Bidding Implementation Contractor (CBIC) Web site at *www.dmecompetitivebid.com*.

DMEPOS Competitive Bidding Program Competitive Bidding Areas Are Defined by ZIP Codes

Two CBA ZIP code files have been posted on the Competitive Bidding Implementation Contractor (CBIC) Web site:

- one file containing mail order ZIP codes per CBA
- one file containing non-mail order ZIP codes per CBA.

These files will be updated on a quarterly basis, as needed, to reflect changes in ZIP codes included in the various CBAs. Although the boundaries of a CBA will not change during a competitive bidding contract period, ZIP codes in general do change from time to time (e.g., when one ZIP code/area is subdivided into two or more new ZIP codes/areas, etc.).

ZIP codes contained in each CBA may be accessed through the CMS DMEPOS Competitive Bidding Web site at located at *www.cms.hhs.gov/DMEPOSCompetitivebid/*. Just click on the "Metropolitan Statistical Areas, Competitive Bidding Areas, and ZIP Codes" tab and scroll down to "Related Links Outside CMS."

Important Requirements of the "Grandfathered" Supplier Provision

Noncontract suppliers located in the 10 DMEPOS CBAs should have taken the appropriate steps to notify beneficiaries whose permanent residence is in a CBA of their decision to become, or not to become grandfathered suppliers for each competitively bid item. **These decisions**

Medicare DMEPOS Competitive Bidding Program News (continued)

should be conveyed through a written notification to the beneficiary before the start date of the new program.

Note: This notification should only be sent to beneficiaries who maintain a permanent residence in a CBA.

Suppliers can determine if a beneficiary resides in a CBA by comparing the beneficiary's ZIP code to the ZIP code files on the CBIC's Web site.

Suppliers that choose to become "grandfathered" should maintain a record as to whether the beneficiary chose to continue to receive the item from the grandfathered supplier, chose to go to a contract supplier, or did not respond.

For suppliers that choose not to become grandfathered, the beneficiary will have to switch to a contract supplier.

CMS expects suppliers to work together to ensure there is no break in service or in the furnishing of medically necessary items (e.g., oxygen, enteral nutrition, CPAP). In order for this transition to occur, a coordinated effort including delivery and pick-up of supplies must take place.

For more detailed information on this topic, please refer to the *MLN Matters* article MM5978 and the *Medicare Learning Network's* Tip Sheet for "Grandfathered" Suppliers on the CMS DMEPOS Competitive Bidding Web site located at *www.cms.hhs.gov/DMEPOSCompetitivebid/*.

Go to the "Provider Educational Products and Resources" tab and scroll to the "Downloads" section. ❖

Source: CMS Provider Education Resource 200806-19

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DMEPOS Competitive Bidding News

Clarification of Mail Order

The Centers for Medicare & Medicaid Services (CMS) has posted information on the competitive bidding implementation contractor (CBIC) Web site to clarify its policy with regard to mail order suppliers. This posting provides further guidance on common carriers and local storefront suppliers. For more information, please visit the Supplier's Frequently Asked Questions (FAQs) section at *http://www.dmecompetitivebid.com*. ❖

Source: CMS Provider Education Resource 200806-25

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.*

Medicare DMEPOS Competitive Bidding Program Began July 1, 2008

If you Refer or Order DMEPOS for Medicare Beneficiaries

Under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program, beneficiaries who permanently reside in or travel to a designated competitive bidding area (CBA) are required to obtain competitive bid items from a contract supplier, unless an exception applies (e.g., grandfathered suppliers). You (e.g., physicians, practitioners, discharge planners, social workers, pharmacists, and home health agencies) will play a critical role in helping your DMEPOS contract suppliers. The *Medicare Learning Network's* "Tip Sheet for Referral Agents" can help! Downloadable copies are available at *www.cms.hhs.egov/DMEPOSCompetitivBid*. Click on the "Provider Educational Products and Resources" tab on the left then scroll down to the "Downloads" section.

Enteral Nutrition is not a "Grandfathered" Competitively Bid Item

Under the DMEPOS Competitive Bidding Program, enteral nutrition must be furnished by a contract supplier and cannot be provided by a noncontract-grandfathered supplier. To ensure that there is no gap in service, this is important information for providers who order enteral nutrition for Medicare beneficiaries who permanently reside in, or are visiting a CBA.

There is no Application or Registration Required to Become a Grandfathered Supplier

Suppliers servicing Medicare patients in a CBA need only notify their Medicare clients that they have elected to become a grandfathered supplier and receive a response that the Medicare beneficiary elects to continue services. For more details, see the "DMEPOS Grandfathered Suppliers" tip sheet on the Centers for Medicare & Medicaid Services (CMS) dedicated Web site at *www.cms.hhs.gov/DMEPOSCompetitiveBid*. Click on the "Provider Educational Products and Resources" tab on the left then scroll down to the "Downloads" section.

New Frequently Asked Questions (FAQ) Now Posted on the CMS Web Site

Twenty-six new frequent asked questions (FAQs) have recently been posted on the CMS DMEPOS Competitive Bidding provider Web site. See what's new by going to *www.cms.hhs.gov/DMEPOSCompetitiveBid*. Click on the "Provider Educational Products and Resources" tab on the left then scroll down to "Related Links Inside CMS".

Medicare DMEPOS Competitive Bidding Program Began July 1, 2008 (continued)

NEW *MLN MATTERS* ARTICLE ON CMS CLAIMS PROCESSING MANUAL REVISIONS

The CMS has issued change request (CR) 6007, Manual Revisions to Reflect Special Billing Instructions for DMEPOS Items as a Result of the DMEPOS Competitive Bidding Program and the corresponding *MLN Matters* article. The article is available at *www.cms.hhs.gov/MLNMattersArticles/downloads/MM6007.pdf* and will also be available on the "Provider Educational Products and Resources" page of the CMS DMEPOS Competitive Bidding provider Web site soon.

WEB SITE ADDITION – SINGLE PAYMENT AMOUNTS

A new link to DMEPOS Competitive Bidding single payment amounts has been added to the dedicated Web site to allow easy access to the files that list the single payment amount for competitively bid items. Go to *www.cms.hhs.gov/DMEPOSCompetitiveBid* and click on the "Single Payment Amounts" tab on the left.

All the information that you need to know as a DMEPOS supplier, or an enrolled Medicare provider who refers beneficiaries for DMEPOS is available on the CMS DMEPOS Competitive Bidding dedicated Web site located at *www.cms.hhs.gov/DMEPOScompetitivebid*. ❖

Visit the Medicare Learning Network – It's Free!

Source: CMS Provider Education Resource 200806-23

PHASE 2 OF MANUAL REVISIONS FOR THE DMEPOS COMPETITIVE BIDDING PROGRAM

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

Note: This *MLN Matters* article is impacted by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, which was enacted on July 15, 2008. That legislation delays the implementation of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program until 2009 and makes other changes to the program. This article will be further revised and/or replaced as more details of the modified program are available. The *MLN Matters* article MM6119 was published in the July 2008 *Medicare A Bulletin* (pages 21-25).

PROVIDER TYPES AFFECTED

All Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers who bill DME Medicare administrative contractors (MACs) as well as any providers who refer or order DMEPOS for Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request (CR) 6119, from which this article is developed, is the second installment of, and adds information to, chapter 36 DMEPOS Competitive Bidding program in the *Medicare Claims Processing Manual*. CR 5978 provided the first installment of chapter 36 and details the initial requirements of this program. The companion MLN Matters article to CR 5978 is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5978.pdf*.

Chapter 36 manualizes policies and instructions for Medicare contractors on the DMEPOS Competitive Bidding program. Subsequent installments may follow providing additional sections to the chapter.

This article complements *MLN Matters* articles MM5978, SE0805, SE0806, and SE0807, which already cover many of the sections of the new chapter being added to the *Medicare Claims Processing Manual*. These articles in combination with this one cover the key sections of chapter 36.

BACKGROUND

The Medicare payment for most DMEPOS is currently based on fee schedules. However, in amending section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates a competitive bidding program to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

In compliance with the statute mandate that this competitive bidding program be phased-in beginning in 2007, CMS issued the regulation for the competitive bidding program (published on April 10, 2007 (72 *Federal Register* 68 (10 April 2007) pp. 17991-18090)). This regulation is available on the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid*.

KEY POINTS OF CHANGE REQUEST 6119

Key points of CR 6119 that address a number of areas detailed in chapter 36 of the *Medicare Claims Processing Manual* are as follows:

Home Health Agencies

Home health agencies must submit a bid and be awarded a contract for the DMEPOS Competitive Bidding program in order to furnish competitively bid items directly to Medicare beneficiaries who maintain a permanent residence in a competitive bidding area (CBA). If a home health agency is not awarded a contract to furnish competitively bid items, then they must use a contract supplier for these items.

Prescription for Particular Brand, Item, or Mode of Delivery

Contract suppliers are required to furnish a specific brand name item or mode of delivery to a beneficiary if prescribed by a physician or treating practitioner (that is a physician assistant, clinical nurse specialist, or nurse practitioner) to avoid an adverse medical outcome for the

Phase 2 of Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome. This documentation should include the following:

- The product brand name or mode of delivery
- The features that this product or mode of delivery has versus other brand name products or modes of delivery.
- An explanation of how these features are necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery to avoid an adverse medical outcome, the contract supplier must either:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription for Medicare payment. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

Payment for Rental of Inexpensive or Routinely Purchased DME

The monthly rental payment amounts for inexpensive or routinely purchased DME (identified using Healthcare Common Procedure Coding System [HCPCS] modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item.

Payment for Oxygen and Oxygen Equipment

The monthly payment amounts for oxygen and oxygen equipment are equal to the single payment amounts established for the following classes of items:

- Stationary oxygen equipment (including stationary oxygen concentrators) and oxygen contents (stationary and portable)
- Portable equipment only (gaseous or liquid tanks)
- Oxygen generating portable equipment (OGPE) only (used in lieu of traditional portable oxygen equipment/ tanks)
- Stationary oxygen contents (for beneficiary-owned stationary liquid or gaseous equipment)
- Portable oxygen contents (for beneficiary-owned portable liquid or gaseous equipment).

In cases where a supplier is furnishing both stationary oxygen contents and portable oxygen contents, the supplier is paid both the single payment amount for stationary oxygen contents and the single payment amount for portable oxygen contents. The payment amounts for purchase of supplies and accessories used with beneficiary-owned oxygen equipment are equal to the single payment amounts established for the supply or accessory.

Change in Suppliers for Oxygen and Oxygen Equipment

The following rules apply when the beneficiary switches from one supplier of oxygen and oxygen equipment to another supplier after the beginning of each round of competitive bidding:

Noncontract supplier to contract supplier

In general, monthly payment amounts may not exceed a period of continuous use of longer than 36 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 36-month period, at least 10 monthly payment amounts would be made to a contract supplier that begins furnishing oxygen and oxygen equipment in these situations provided that medical necessity for oxygen continues.

For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months two through 26, payment would be made for the remaining number of months in the 36-month period, because the number of payments to the contract supplier would be at least 10 payments. To provide a more specific example, a contract supplier that begins furnishing oxygen equipment beginning with the 20th month of continuous use would receive 17 payments (17 for the remaining number of months in the 36-month period). However, if a contract supplier begins furnishing oxygen equipment to a beneficiary in month 27 or later, no more than 10 monthly payments would be made assuming the oxygen equipment remains medically necessary.

Contract supplier to another contract supplier

This rule does not apply when a beneficiary switches from a contract supplier to another contract supplier to receive his/her oxygen and oxygen equipment. In this scenario, the new contract supplier is paid based on the single payment amount for the remaining number of months in the 36-month period assuming the oxygen equipment remains medically necessary.

Payment for Capped Rental DME Items

The monthly rental payment amounts for capped rental DME (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first three months and 7.5 percent of the single payment amount established for purchase of the item for months four through 13.

Change in Suppliers for Capped Rental DME Items

The following rules apply when the beneficiary switches from one supplier of capped rental DME to another supplier after the beginning of each round of competitive bidding:

Noncontract supplier to contract supplier

In general, rental payments may not exceed a period of continuous use of longer than 13 months.

Phase 2 of Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 13-month rental period, a new 13-month period begins and payment is made on the basis of the single payment amounts described above under "Payment for Capped Rental DME Items". The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the new 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary. Once the beneficiary switches from a noncontract supplier to a contract supplier, he/she may not switch back to a noncontract supplier if he/she continues to maintain a permanent residence in a CBA. If, however, the beneficiary relocates out of the CBA to a non-CBA, then he/she may switch to a noncontract supplier and a new 13-month rental period does not begin.

Contract supplier to another contract supplier

If the beneficiary switches from one contract supplier to another contract supplier before the end of the 13-month rental period, a new 13-month period does not begin. This rule applies in situations where the beneficiary changes suppliers within a CBA and in situations where the beneficiary relocates and switches from a contract supplier in one CBA to a contract supplier in another CBA. The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary.

Payment for Purchased Equipment

Payment for purchase of new equipment (identified using HCPCS modifier NU), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 100 percent of the single payment amounts established for these items. Payment for purchase of used equipment (identified using HCPCS modifier UE), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 75 percent of the single payment amounts established for new purchase equipment items.

Payment for Repair and Replacement of Beneficiary-Owned Equipment

Beneficiaries who maintain a permanent residence in a CBA may go to any Medicare-enrolled supplier (contract or noncontract supplier) for the maintenance or repair of beneficiary-owned equipment, including parts that need to be replaced in order to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and, therefore, will be paid in accordance with Medicare's general payment rules. Payment for replacement parts that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount in that CBA for that replacement part. Payment is not made for parts and labor covered under a manufacturer's or supplier's warranty.

Beneficiaries must obtain replacements of all items that are part of the competitive bidding program for the areas in which the beneficiary resides from a contract supplier unless the item is a replacement part or accessory that is replaced as part of the service of repairing beneficiary-owned base equipment (e.g., wheelchair, walker, hospital bed, continuous positive pressure airway device, oxygen concentrator, etc.). All base equipment that is replaced in its entirety because of a change in the beneficiary's medical condition or because the base equipment the beneficiary was using was either lost, stolen, irreparably damaged, or used beyond the equipment's reasonable useful lifetime (see section 110.2.C of chapter 15 of the *Medicare Benefit Policy Manual* on the CMS Web site at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf*) must be obtained from a contract supplier in order for Medicare to pay for the replacement. Payment for replacement of items that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount for that item. The contract supplier is not required to replace an entire competitively bid item with the same make and model as the previous item unless a physician or treating practitioner prescribes that make and model.

If beneficiary-owned oxygen equipment or capped rental DME that is a competitively bid item for the CBA in which the beneficiary maintains a permanent residence has to be replaced prior to the end of its reasonable useful lifetime, then the replacement item must be furnished by the supplier (contract or noncontract supplier) that transferred ownership of the item to the beneficiary.

Payment for Enteral Nutrition Equipment

The monthly rental payment amounts for enteral nutrition equipment (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first three months and 7.5 percent of the single payment amount established for purchase of the item for months four through 15.

Maintenance and Servicing of Enteral Nutrition Equipment

The contract supplier that furnishes the equipment to the beneficiary in the 15th month of the rental period must continue to furnish, maintain, and service the equipment after the 15 month rental period is completed until a determination is made by the beneficiary's physician or treating practitioner that the equipment is no longer medically necessary. The payment for maintenance and servicing enteral nutrition equipment is five percent of the single payment amount established for purchase of the item.

Traveling Beneficiaries

Beneficiaries, who travel outside their CBA, for example, to visit family members or reside in a state with warmer climates during winter months, need to consider the following three factors when traveling:

Phase 2 of Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

- Where to go to obtain a DMEPOS item.
- Identify whether the item is a competitively bid item or not.
- Determine the Medicare payment amount for that item.

Depending on where the beneficiary travels (whether to a CBA or a non-CBA), the beneficiary may need to obtain DMEPOS from a contract supplier in order for Medicare to cover the item. For example, a beneficiary who travels to a non-CBA may obtain DMEPOS, if medically necessary, from any Medicare-enrolled supplier. On the other hand, a beneficiary who travels to a CBA should obtain competitively bid items in that CBA from a contract supplier in that CBA in order for Medicare to cover the item. The chart below shows whether a beneficiary should go to a contract supplier or any Medicare-enrolled supplier when the beneficiary travels.

Beneficiary Permanently Resides in	Travels to	Type of Supplier
a CBA	a CBA	The beneficiary should obtain competitively bid items in that CBA from a contract supplier located in that CBA if the beneficiary wants Medicare to cover the item.
	a non-CBA	Medicare will cover DMEPOS, if medically necessary, from any Medicare-enrolled DMEPOS supplier.
a non-CBA	a CBA	The beneficiary should obtain the competitively bid item from a contract supplier in the CBA if the beneficiary wants Medicare to cover the item.
	a non-CBA	Medicare-enrolled DMEPOS supplier.

Suppliers that furnish DMEPOS items to Medicare beneficiaries who maintain a permanent residence in a CBA and who travel to a non-CBA need to be aware of the public use files on the competitive bidding implementation contractor (CBIC) Web site at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

These files contain the ZIP codes for the CBAs, the HCPCS codes for competitively bid items, and related single payment amounts for competitively bid items. The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. For example:

1. If a beneficiary maintains a permanent residence in a CBA and travels outside of the CBA, payment for a competitively bid item for the CBA in which the beneficiary maintains a permanent residence is the single payment amount for that item in the beneficiary's CBA.
2. When a beneficiary maintains a permanent residence in an area that is not in a CBA and travels to CBA or non-CBA, the supplier that furnishes the item will be paid the fee schedule amount for the area where the beneficiary maintains a permanent residence.

Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items

If a beneficiary who has two residences in different areas and uses a local supplier in each area or if a beneficiary changes suppliers during or after the rental period, this does not result in a new rental episode. The supplier that provides the item in the 36th month of rental for oxygen equipment or the 13th month of rental for capped rental DME is responsible for transferring title to the equipment to the beneficiary. This applies to "snow bird" or extended travel patients and coordinated services for patients who travel after they have purchased the item.

Advance Beneficiary Notice

Billing Procedures Related to Advance Beneficiary Notice Upgrades Under the Competitive Bidding Program

In general, a contract supplier must furnish an item included in a competitive bidding program for Medicare to make payment. This requirement applies to situations where the item is furnished directly or indirectly as an upgrade. An upgrade is an item with features that go beyond what is medically necessary. An upgrade may include an excess component. An excess component may be an item feature or service, which is in addition to, or is more extensive than, the item that is reasonable and necessary under Medicare coverage requirements. An item is indirectly furnished if Medicare makes payment for it because it is medically necessary and is furnished as part of an upgraded item. The billing instructions for upgraded equipment found in section 120 of chapter 20 of the *Medicare Claims Processing Manual* (available on the CMS Web site at *http://www.cms.hhs.gov/manuals/Downloads/clm104c20.pdf*) continue to apply under the DMEPOS Competitive Bidding program. Consider the following:

1. **Where a beneficiary, residing in a competitive bidding area, elects to upgrade to an item with features or upgrades that are not medically necessary:**
   - **Upgrades from a bid item to a non-bid item**
     In this situation, Medicare payment will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.
   - **Upgrades from a non-bid item to a bid item**
     When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of

Phase 2 of Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")**
  In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S."

2. **Where a beneficiary, who does not reside in a competitive bidding area, but travels to a competitive bidding area, elects to upgrade to an item with features that are not medically necessary:**

   - **Upgrades from a bid item to a non-bid item**
     In this situation, Medicare payment is only made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.
   - **Upgrades from a non-bid item to a bid item**
     When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.
   - **Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")**
     In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S."

Note: In the *Medicare Claims Processing Manual* chapter 36 section 40.11 attached to CR 6119 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf*, a detailed chart describe situations where a beneficiary, residing in a CBA, elects to upgrade to an item with features or upgrades that are not medically necessary.

Beneficiary Liability

Under the competitive bidding program, a beneficiary has no financial liability to a noncontract supplier that furnishes an item included in the competitive bidding program for a competitive bidding area, unless the beneficiary has signed an advance beneficiary notice (ABN). Similarly, beneficiaries who receive an upgraded item from a noncontract supplier in a competitive bidding area are not financially liable for the item unless the supplier has obtained a signed ABN from the beneficiary.

In the case of upgrades, for a beneficiary to be liable for the extra cost of an item that exceeds their medical needs, the beneficiary must sign the appropriate ABN. See chapter 20, section 120 of the *Medicare Claims Processing Manual* on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf* or additional information on ABN upgrades.

Billing Procedures Related to Downcoding Under the Competitive Bidding Program

The following downcoding guidelines describe situations where Medicare reduces the level of payment for the prescribed item based on a medical necessity partial denial of coverage for the additional, not medically necessary, expenses associated with the prescribed item.

1. **For beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare coverage requirements.**

   - **Downcodes from a non-bid item to a bid item**
     In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.
   - **Downcodes from a bid item to a non-bid item**
     Medicare payment in this downcoding scenario will be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.
   - **Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")**
     In this case, Medicare payment will be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S."

2. **For a beneficiary who does not reside in a CBA, but travels to a CBA and for whom Medicare determines that the prescribed item is downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.**

   - **Downcodes from a non-bid item to a bid item**
     In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.
   - **Downcodes from a bid item to a non-bid item**
     Medicare payment in this downcoding scenario will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

Phase 2 of Manual Revisions for the DMEPOS Competitive Bidding Program (continued)

- **Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")**
  In this case, Medicare payment will only be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S."

A detailed chart of downcoding scenarios is in the new chapter 36, section 40.12 (attached to CR 6119) for beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.

ADDITIONAL INFORMATION

You may find more information about the payment changes for DMEPOS items as a result of the DMEPOS competitive bidding program and the Deficit Reduction Act of 2005 by going to CR 6119, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf*.

You will find the updated *Medicare Claims Processing Manual, c*hapter 36 *(*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program) as an attachment to that CR.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, may be found on the CMS dedicated Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/*.

Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

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

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

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GENERAL COVERAGE

CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY FOR OBSTRUCTIVE SLEEP APNEA

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

PROVIDER TYPES AFFECTED

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

IMPACT ON PROVIDERS

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

BACKGROUND

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

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

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

Key Points of Change Request 6048

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

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

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

   - Polysomnography (PSG) performed in a sleep laboratory.
   - Unattended home sleep monitoring device of Type II.
   - Unattended home sleep monitoring device of Type III.
   - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels.

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

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

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

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

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of

Continuous Positive Airway Pressure Therapy for Obstructive Sleep Apnea (continued)

events that would have been required in a two-hour period.

5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.

6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or type II, type III, or a type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *NCD Manual* revision attached to CR 6048. Medicare will process claims according to coverage with evidence development (CED)/clinical trials criteria at section 310.1 of the *NCD Manual* and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available on the CMS Web site at *http://www.cms.hhs.gov/manuals/IOM/list.asp*.

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

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

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

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

Additional Information

To see the official instruction (CR 6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R91NCD.pdf*.

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

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

MLN Matters Number: MM6048
Related Change Request (CR) Number: 6048
Related CR Release Date: July 25, 2008
Related CR Transmittal Number: R91NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

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

Intracranial Percutaneous Transluminal Angioplasty with Stenting

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

Provider Types Affected

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for percutaneous transluminal angioplasty (PTA) with stenting.

What Providers Need to Know

Be aware that the Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and on May 12, 2008, posted a final decision memorandum following reconsideration of its national coverage determination (NCD) on PTA with intracranial stent placement at section 20.7.B.5 of the *Medicare NCD Manual*. With change request (CR) 6137, **CMS reaffirms its existing NCD with no changes, and will continue to cover PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis ≥ 50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the Food and Drug Administration (FDA)-approved protocols governing category B investigational device exemption (IDE) clinical trials.** CMS will continue its national noncoverage for all other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries.

Background

This article is based on CR 6137, which responds to a request on August 24, 2007, by the manufacturer to reconsider and expand coverage to include coverage with evidence development (CED) for intracranial stenting and angioplasty for patients in the IDE clinical trails.

Additional Information

You may see the official instruction (CR 6137) issued to your Medicare carrier, FI, or A/B MAC, by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R87NCD.pdf*.

Section 20.7 of the *Medicare NCD Manual* is attached to CR 6137.

You may also review *MLN Matters* article MM5432, which preceded this article and provides the previous CMS response to PTA with stenting on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5432.pdf*.

Intracranial Percutaneous Transluminal Angioplasty with Stenting (continued)

If you have 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: MM6137
Related Change Request (CR) Number: 6137
Related CR Release Date: July 11, 2008
Related CR Transmittal Number: R87NCD
Effective Date: May 12, 2008
Implementation Date: August 11, 2008

Source: CMS Pub. 100-03, Transmittal 87, CR 6137

CARDIAC COMPUTED TOMOGRAPHIC ANGIOGRAPHY

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 cardiac computed tomographic angiography (CTA) services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is informational only and based on change request (CR) 6098 which announces that the Centers for Medicare & Medicaid Services (CMS), upon review of the available evidence, has determined that the coverage of cardiac CTA to diagnosis coronary artery disease (CAD) will remain at local Medicare contractor discretion, and no national coverage determination (NCD) is appropriate at this time.

BACKGROUND

CTA is a noninvasive method (using intravenous contrast) to visualize the coronary arteries (or other vessels) using high resolution, high speed computed tomography (CT).

After examining the medical evidence, CMS has determined that no NCD is appropriate at this time, effective March 12, 2008. Pursuant to the Social Security Act (Section 1862[a][1][A]), local contractors should make decisions through:

- the local coverage determination process
- case-by-case adjudication

Therefore, all claims for CTA used to diagnose CAD will continue to be determined by local Medicare contractor discretion and section 220.1 of Publication 100-03 of the *NCD Manual* remains unchanged.

ADDITIONAL INFORMATION

The official instruction, CR 6098, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R85NCD.pdf*.

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

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

MLN Matters Number: MM6098
Related Change Request (CR) Number: 6098
Related CR Release Date: June 27, 2008
Related CR Transmittal Number: R85NCD
Effective Date: March 12, 2008
Implementation Date: July 28, 2008

Source: CMS Pub. 100-03, Transmittal 85, CR 6098

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

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*.

NEW LCD IMPLEMENTATION

A84999: GENE EXPRESSION PROFILING PANEL FOR USE IN THE MANAGEMENT OF BREAST CANCER TREATMENT—NEW LCD

LCD ID NUMBER L28088

Genomics focuses on how the complex set of genes in the genome are expressed and interact to regulate cell behavior in health and disease. An important genomic parameter is the pattern of gene expression, which can be ascertained by measuring the levels of expressed ribonucleic acid (RNA). To date, therapeutic decisions for locally advanced breast cancer are mainly guided by clinicopathological parameters, such as patient age and functional status, comorbidities, estrogen receptor status, tumor grade, tumor size and lymph node status. Clinical studies have shown that incorporation of gene expression signatures into clinical risk stratification may be useful for prognostic and therapeutic strategies in breast carcinoma.

The application of gene expression profiling using Oncotype DX® is employed to identify patients who are predicted to obtain the most therapeutic benefit from adjuvant tamoxifen and may not require adjuvant chemotherapy. The Oncotype DX® (Genomic Health, Redwood City, California), uses reverse transcription polymerase chain reaction (RT-PCR) to determine the expression of a panel of 21 genes isolated from formalin-fixed, paraffin-embedded tissue (FPET).

A recurrence score (RS) is calculated from the gene expression results using a proprietary Oncotype DX® algorithm, which is then used to assign a patient to one of three groups by estimated risk of distant recurrence: low, intermediate and high. Patients with high recurrence scores (RS) appear to achieve relatively more benefit from adjuvant chemotherapy.

This test is provided throughout the United States by the Clinical Laboratory Improvement Amendments (CLIA)-regulated laboratory of Genomic Health Inc., in Northern California. Therefore, when this test is a Part B service, most or all coverage decisions for Medicare beneficiaries are made by the Part B contractor serving Genomic Health, Inc., which is National Heritage Insurance Company (NHIC).

INDICATIONS

First Coast Service Options Inc. (FCSO) will consider the application of gene expression profiling using Oncotype DXTM as medically reasonable and necessary, with case by case review as needed, when used to assess the need for adjuvant chemotherapy in patients with recently diagnosed breast cancer (six months or less have elapsed) when **all of the following criteria are met:**

- Breast cancer is nonmetastatic (node-negative) (lymph nodes with micrometastases are not considered positive).
- Breast cancer is unilateral and non-fixed (i.e., tumor not adhered to chest wall).
- Breast tumor is hormone receptor-positive (estrogen receptor (ER)-positive or progesterone receptor (PR)-positive).
- Breast tumor is HER2-receptor negative.
- Breast tumor size is 0.6-1 cm with moderate/poor differentiation or unfavorable features, OR tumor size is >1 cm.
- Breast tumor is stage 1 or stage II.
- Breast cancer will be treated with hormonal therapy.
- Adjuvant chemotherapy is not precluded due to any other factor (e.g., advanced age and/or significant co-morbidities).
- Testing is being done specifically to guide the decision as to whether or not adjuvant chemotherapy will be used and, prior to testing the patient and oncologist have discussed the potential results of the test and agree to use the results to guide therapy (i.e., the patient will forgo adjuvant chemotherapy if Oncotype DX® score is low).

Medical tests are covered only when ordered by the treating oncologist, when necessary for diagnosis or treatment decisions, and when used in patient care (42 CFR 410.32).

EFFECTIVE DATE

This new local coverage determination (LCD) is effective for services provided **on or after September 30, 2008.**

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

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.

ADDITIONS/REVISIONS TO EXISTING LCDS

A93303: TRANSTHORACIC ECHOCARDIOGRAPHY (TTE)—REVISION TO THE LCD

LCD ID NUMBER L1566

The local coverage determination (LCD) for transthoracic echocardiography (TTE) was last revised on January 10, 2008. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 6094 (July 2008 Update of the Hospital Outpatient Prospective Payment System [OPPS]), Transmittal 1536, dated June 19, 2008, which included HCPCS code descriptor changes. Therefore, the LCD has been revised to include the following HCPCS code descriptor changes:

C8921 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete

C8922 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study

C8923 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D) with or without m-mode recording; complete

C8924 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D) with or without m-mode recording; follow-up or limited study

EFFECTIVE DATE

This revision to the LCD is effective for services provided **on or after April 1, 2008.**
First Coast Service Options LCDs are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

A93312: TRANSESOPHAGEAL ECHOCARDIOGRAM—REVISION TO THE LCD

LCD ID NUMBER L1584

The local coverage determination (LCD) for transesophageal echocardiogram was last revised on January 1, 2008. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 6094 (July 2008 Update of the Hospital Outpatient Prospective Payment System [OPPS]), transmittal 1536, dated June 19, 2008, which included HCPCS code descriptor changes. Therefore, the LCD has been revised to include the following HCPCS code descriptor changes:

C8925 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by 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, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report

C8927 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by 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

EFFECTIVE DATE

This revision to the LCD is effective for services provided **on or after April 1, 2008.**
First Coast Service Options LCDs are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

AG0237: RESPIRATORY THERAPEUTIC SERVICES—REVISION TO THE LCD

LCD ID NUMBER L15017

The local coverage determination (LCD) for respiratory therapeutic services was last revised on June 9, 2005. Since that time, the LCD has been revised. Change request 5898, dated February 22, 2008, updated billing requirements for comprehensive outpatient rehabilitation facilities (CORF). The "Revenue Codes" section of the LCD has been revised to remove revenue codes 41x, 42x, and 43x and add revenue codes 0410, 0412, and 0419. Revenue codes 0410, 0412, and 0419 were also added to the "coding guidelines" attachment for the LCD.

EFFECTIVE DATE

This revision to the LCD is effective for claims processed **on or after July 7, 2008,** for services provided **on or after July 1, 2008.**

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

AJ9355: TRASTUZUMAB (HERCEPTIN®)—REVISION TO THE LCD

LCD ID NUMBER L25127

The local coverage determination (LCD) for trastuzumab (Herceptin®) was last updated on January 18, 2008. Since that time, a revision was made to update language for additional 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 for adjuvant and metastatic breast cancer. The LCD now has the following verbiage for these indications:

Adjuvant Breast Cancer

Herceptin is indicated for adjuvant treatment of HER2-overexpressing node positive or node negative (ER/PR negative or with one high risk feature) breast cancer:

- As part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel
- As a single agent following multi-modality anthracycline based therapy

Metastatic Breast Cancer

Herceptin is indicated:

- In combination with paclitaxel for first-line treatment of HER2-overexpressing metastatic breast cancer
- As a single agent for treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastic disease

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

EFFECTIVE DATE

This revision to the LCD is effective for services provided **on or after May 22, 2008.**

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

ANCSVCS: THE LIST OF MEDICARE NONCOVERED SERVICES—REVISION TO THE LCD

LCD ID NUMBER L24028

The local coverage determination (LCD) for the list of Medicare noncovered services was last updated on June 30, 2008. Since that time, the LCD has been revised to add *CPT* codes *0190T* and *0191T* to the "Procedures" subsection under the "CPT/HCPCS Codes Local Noncoverage Decisions" section of the LCD, as these procedures are considered investigational.

EFFECTIVE DATE

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

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

ANCSVCS: THE LIST OF MEDICARE NONCOVERED SERVICES—REVISION TO THE LCD

LCD ID NUMBER L24028

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised July 1, 2008. Since that time, the LCD has been revised to add HCPCS code C9727/*CPT* code *42299* (Palatal implants [Pillar™]) to the list of procedures under the "local noncoverage" decisions section of the LCD. Palatal implants (Pillar™) are considered experimental and investigational.

EFFECTIVE DATE

This revision to the LCD is effective for services provided **on or after September 30, 2008.**
First Coast Service Options LCDs are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

AVISCO: VISCOSUPPLEMENTATION THERAPY FOR KNEE—REVISION TO THE LCD

LCD ID NUMBER L1600

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised March 20, 2008. Since that time, a revision was made to the LCD to clarify coverage guidelines regarding the frequency of courses of treatment allowed, documentation guidelines to support frequency of courses of treatment, conservative treatment, and the use of imaging when administering viscosupplementation of the knee.

EFFECTIVE DATE

This revision to the LCD is effective for services provided **on or after September 30, 2008.**
First Coast Service Options LCDs are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

ADDITIONAL MEDICAL INFORMATION

ATHERSVCS: THERAPY AND REHABILITATION SERVICES—REVISION TO CODING GUIDELINES

LCD ID NUMBER L1125

The "coding guidelines" attachment for the therapy and rehabilitation services local coverage determination (LCD) was last revised on April 1, 2008. Since that time, it has been revised. Change request 5898, dated February 22, 2008, updated billing requirements for comprehensive outpatient rehabilitation facilities (CORF). Language has been added to the "coding guidelines" attachment listing the applicable revenue codes for type of bill (TOB) 75x. These revenue codes are:

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

EFFECTIVE DATE

This revision to the "coding guidelines" attachment is effective for claims processed **on or after July 7, 2008,** for services provided **on or after July 1, 2008.**
First Coast Service Options LCDs are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

J9025: VIDAZA® AND ADMINISTRATION *CPT* CODE *96401*—CLARIFICATION OF CORRECT BILLING

There has been recent discussion between First Coast Service Options Inc. (FCSO) and providers regarding VIDAZA® and chemotherapy administration *CPT* code *96401 (Chemotherapy administration, subcutaneous or intramuscular; non-hormonal).*

VIDAZA® is indicated for treatment of patients with the following myelodysplastic syndrome subtypes:

- Refractory anemia or refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusion)
- Refractory anemia with excess blasts
- Refractory anemia with excess blasts in transformation
- Chronic myelomonocytic leukemia (CMML)

VIDAZA® may be administered intravenously or subcutaneously. Discussion between FCSO and the provider community regarding VIDAZA® administration has focused on the subcutaneous route. For subcutaneous administrations of VIDAZA® where the dose is greater than 4 mL, the dose should be divided equally into two syringes and administered into two different sites. Oncology offices are paid extra for chemo administration (as opposed to other drug administration) given the risk and side effects associated with these drugs and the associated overhead to monitor. There is **not** a doubling of risk given the dose is split between two injections that are given one after the other. The additional cost for the syringe and nurse work is not a major factor since the code is weighted three times a therapeutic injection. Therefore, FCSO would not expect to see more than 1 unit of *CPT* code *96401* billed for the administration of VIDAZA®. ❖

HOSPITAL SERVICES

REINSTATEMENT OF MORATORIUM FOR ILS BILLING PATHOLOGY TC FOR HOSPITAL PATIENTS

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory (IL) could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, the carriers and, more recently, Medicare administrative contractors (MAC) have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), section 104, expired on June 30, 2008. A new extension of the moratorium has been established by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, section 136, retroactive to July 1, 2008.

A previous communication indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010. ❖

Source: CMS Provider Education Resource 200807-23
CMS JSM 08413, July 16, 2008

NEW HEMOPHILIA CLOTTING FACTOR AND HCPCS CODE

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

PROVIDER TYPES AFFECTED

Hospital providers submitting inpatient 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) 6006 which announces that Healthcare Common Procedure Coding System (HCPCS) code Q4096 (injection, von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per I.U. vWF:RCO vWF complex, NOS) will be payable for Medicare effective for claims with dates of service on or after April 1, 2008. Appropriate systems changes for editing hemophilia clotting factors **on inpatient claims** will not be made by the Medicare fiscal intermediary shared system (FISS) until January 5, 2009, release. This CR does not impact outpatient hospital claims or on any skilled nursing facility (SNF) claims as payment is made under different methodologies. HCPCS code Q4096 is payable in those settings effective April 1, 2008.

Providers need to be aware of the instructions in the rest of this article in order to properly submit inpatient claims with HCPCS code Q4096 for discharges on or after April 1, 2008 through January 5, 2009.

BACKGROUND

Effective for claims with dates of service on or after April 1, 2008, the new HCPCS code Q4096 listed below will be payable for Medicare:

Q4096 Injection, von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per I.U. vWF:RCO vWF complex, NOS
Short Descriptor: VWF complex, not Humate-P (NOS)

This factor (HCPCS code Q4096) is payable on inpatient claims effective April 1, 2008, and appropriate systems changes for editing Q4096 on inpatient claims will be made in the FISS on January 5, 2009.

During the period between April 1, 2008 and January 5, 2009, the following procedures need to be followed **for inpatient claims:**

- **Hospital providers should submit inpatient claims** to Medicare contractors (FIs and A/B MACs) for inpatient hospital stays during which Alphanate® (for the purposes of treating Von Willebrand disease) was given, **omitting the line item(s) for HCPCS Code Q4096** for dates of discharge on and after April 1, 2008 but prior to January 5, 2009**.** This includes hospitals paid:
  - Under the inpatient prospective payment system (IPPS), including Indian health service (IHS) hospitals
  - Under the long term care prospective payment system (LTCH PPS)
  - Under the inpatient rehabilitation facility prospective payment system (IRF PPS)
  - On the basis of reasonable cost (TEFRA hospitals, and critical access hospitals [CAHs]).

New Hemophilia Clotting Factor and HCPCS Code (continued)

This does not apply to claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS; IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis on the claim. IPFs should refrain from including Q4096 on their inpatient claims.

Note: Medicare contractors will return to provider (RTP) any inpatient claims (type of bill [TOB] 11x) containing HCPCS code Q4096 with discharge dates on and after April 1, 2008, but prior to January 5, 2009.

- **Once the provider has received PPS payment for the inpatient claim, the provider should immediately submit an adjustment request (TOB = 117), this time including a line for HCPCS Code Q4096.**
- **Medicare contractors will hold these provider initiated adjustment requests containing HCPCS Code Q4096 with discharge dates between April 1, 2008, and January 5, 2009.**
- **Once the FISS system changes for Q4096 are implemented on January 5, 2009, Medicare contractors will process all held adjustment requests.**

As a reminder, for fiscal year 2008, the add-on payment for blood clotting factor administered to hemophilia inpatients is based on average sales price (ASP) plus six percent and a furnishing fee. The furnishing fee is updated each calendar year.

ADDITIONAL INFORMATION

The official instruction, CR 6006, issued to your FI and A/B 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/R1564CP.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: MM6006
Related Change Request (CR) Number: 6006
Related CR Release Date: July 25, 200
Related CR Transmittal Number: R1564CP
Effective Date: April 1, 2008
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1564, CR 6006

LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR RATE YEAR 2009

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

PROVIDER TYPES AFFECTED

Long-term care hospitals (LTCHs) claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services paid under the LTCH PPS that are provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on change request (CR) 6114, which announces changes to the LTCH prospective payment system (PPS) for rate year (RY) 2009. Be sure billing staff is ware of this update.

BACKGROUND

On October 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented the LTCH PPS under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. See the *Federal Register*, Vol. 67, No. 169, August 30, 2002, on the Internet at *http://www.access.gpo.gov/su_docs/fedreg/a020830c.html*.

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

CMS is required to update the payments made under the LTCH PPS annually, and since 2004 there have been two significant LTCH PPS updates each year:

1. The federal payment rates update that occur in July of each year (the RY cycle).
2. The LTC-DRG update that occurs in October of each year.

Rate Year 2009 Payment Updates

In the RY 2009 final rule, CMS established a policy to consolidate these two annul update cycles such that the annual updates to both the federal payment rates and the medical severity LTC-DRGs (MS-LTC-DRGs) will occur on October 1 of each year, beginning with October 1, 2009.

To begin this change, RY 2009 will be a 15-month rate year (from July 1, 2008, through September 30, 2009), and all updates to the PRICER for RY 2009 will be made based on calculations reflecting this change.

For the LTCH PPS 2009 RY (July 1, 2008, through September 30, 2009):

- The standard federal rate is $39,114.36.
- The fixed loss amount is $22,960.
- The labor-related share is 75.662 percent.
- The non-labor related share is 24.338 percent.

Long-term Care Hospital Prospective Payment System for Rate Year 2009 (continued)

There is no longer a phase-in of the LTCH PPS wage index adjustment as of cost reporting periods beginning on or after October 1, 2006. Therefore, the wage index table within the PRICER includes only one column that contains the wage index value that will be effective for all LTCH PPS discharges occurring on or after July 1, 2008 through September 30, 2009.

Short-Stay Outlier Payment Adjustment Formula

On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the short-stay outlier (SSO) payment adjustment formula for a three-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a three-year period beginning with discharges occurring on or after December 29, 2007. Therefore, there will be no comparison of the covered length of stay (LOS) of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. For SSO discharges occurring on or after December 29, 2007, and before December 29, 2010, the adjusted payment for a SSO case is equal to the least of:

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

As noted above, during this three-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007.

CR 6114 makes other clarifying language adjustments to chapter 3, section 150.9 (Payment Rate) of the Medicare Claims Processing Manual. That revised section is attached to CR 6114. The CR is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1547CP.pdf*.

Legislative Adjustments to Payment Policy for Co-Located Providers

For hospitals within hospitals (HwH), satellite facilities, and onsite SNFs, the MMSEA legislation also made several changes for a three-year period beginning on December 29, 2007. These changes impact the basic payment formula under the 25 percent threshold payment adjustment for Medicare discharges from referring hospitals. These changes are annotated in a revised chapter 3, section 150.9.1.4 (Payment Policy for Co-Located Providers), which is attached to CR 6114.

COLA Factors for Alaska and Hawaii

Also note that in the LTCH final rule for RY 2009, the cost of living adjustment (COLA) factors for LTCHs located in Alaska and Hawaii are not revised from their current values, and these current COLA factors will continue to be effective for LTCH PPS discharges occurring on or after July 1, 2008 through September 30, 2009. The COLA factors for Alaska and Hawaii hospitals are shown in the following table.

Alaska and Hawaii Hospital Area Cost of Living Adjustment Factors, Effective for Discharge on or After October 1, 2008	
Alaska	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii	
City and county of Honolulu	1.25
County of Hawaii	1.17
City of Kauai	1.25
County Maui and county of Kalawao	1.25

ADDITIONAL INFORMATION

The official instruction, CR 6114, issued to your FI or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1547CP.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: MM6114
Related Change Request (CR) Number: 6114
Related CR Release Date: July 3, 2008
Related CR Transmittal Number: R1547CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008
Source: CMS Pub. 100-04, Transmittal 1547, CR 6114

INPATIENT PSYCHIATRIC FACILITIES PROSPECTIVE PAYMENT SYSTEM RATE YEAR 2009

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

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change request (CR) 6077, from which this article is taken, identifies changes that are required as part of the annual inpatient psychiatric facilities prospective payment system (IPF PPS) update for rate year (RY) 2009. These changes include the market basket update, PRICER updates for IPF PPS rate year (RY) 2009, (July 1, 2008 – June 30, 2009), the stop-loss provision, the electroconvulsive therapy (ECT) update, the payment rate, the national urban and rural cost to charge ratios (CCRs) for the IPF PPS RY 2008, the Medicare severity diagnosis related groups (MS DRG) update, and the cost-of-living adjustment (COLA) for Alaska and Hawaii.

These changes are effective July 1, 2008, and are applicable to IPF discharges occurring during the rate year beginning on July 1, 2008, through June 30, 2009.

In addition, CR 6077 corrects the IPF PPS PRICER to include diagnosis code 07070 (viral hepatitis C without hepatic coma) in calculating a comorbidity adjustment for claims with discharge dates on or after January 1, 2005, through June 30, 2006.

Make sure that your billing staffs are aware of these IPF PPS changes.

BACKGROUND

Under the IPF PPS, payments to inpatient psychiatric facilities are based on a federal per diem base rate that:

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

The Centers for Medicare & Medicaid Services (CMS) is required to update this IPF PPS annually. The RY update is effective July 1 – June 30 of each year and the MS-DRG and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

CR 6077, from which this article is taken, identifies changes that are required as part of the annual IPF PPS update from the RY 2009 IPF PPS update notice, published on May 7, 2008. These changes, which are applicable to IPF discharges occurring during the rate year beginning on July 1, 2008, through June 30, 2009, are presented below.

Market Basket Update

CMS uses the **Rehabilitation/Psychiatric/Long-Term Care** (**RPL**) market basket to update the IPF PPS portion of the blended payment rate (that is the Federal per diem base rate).

PRICER Updates: For IPF PPS Rate Year 2009, (July 1, 2008 – June 30, 2009)

The PRICER updates are as follows:

- The federal per diem base rate is **$637.78.**
- The fixed dollar loss threshold amount is **$6,113.00.**
- The transition from TEFRA to PPS ends in 2008. For cost reporting periods beginning on or after January 1, 2008, payments will be **100 percent PPS.**
- The IPF PPS will use the FY 2008 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is **75.631 percent.**
- The non-labor related share is **24.369 percent.**
- The electroconvulsive therapy (ECT) rate is **$274.58**.

Stop-Loss Provision

To ensure that IPF PPS total payments were no less than a minimum percentage of their TEFRA payment (had the IPF PPS not been implemented), CMS provided a stop-loss payment during the transition from cost-based reimbursement to the per diem payment system. Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent IPF PPS and, therefore, the stop loss provision will no longer be applicable, and the 0.39 percent adjustment to the federal per diem base rate will be removed. Therefore, for RY 2009, the federal per diem base rate and ECT rates will be increased by 0.39 percent. The rates published in CR 6077 include this increase.

Electroconvulsive Therapy (ECT) Update

The update methodology for the ECT rate is to update the previous rate year's amount by the market basket increase, wage index budget neutrality factor and stop-loss premium removal. For RY 2009, the ECT adjustment per treatment is **$274.58**.

Payment Rate

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). The RY 2009 rates (displayed in Table 1, below) were published in the update notice and may also be found on the CMS Web site at *http://www.cms.hhs.gov/InpatientPsychFacilPPS*.

Table 1 – RY 2009 IPF PPS Per Diem Rate

Federal Per Diem Base Rate	$637.78
Labor Share (0.75631)	$482.36
Non-Labor Share (0.24369)	$155.42

The National Urban and Rural Cost to Charge Ratios for the IPF PPS RY 2009

Table 2 below displays the cost to charge ratios **(**CCRs) for RY 2009.

Table 2

Cost to Charge Ratio	Median	Ceiling
Urban	0.537	1.6724
Rural	0.686	1.8041

Inpatient Psychiatric Facilities Prospective Payment System Rate Year 2009 9 (continued)

Please note that the national median CCRs are being applied to the following situations:

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

MS-DRG Update

Since the IPF PPS uses the same GROUPER as the inpatient prospective payment system (IPPS) (including the same diagnostic code set and DRG classification system), the IPF PPS is adopting IPPS' new MS-DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note these are the same adjustment factors that have been in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Table 3, below, displays the crosswalk of current DRGs to the new MS-DRGs, which were effective October 1, 2007:

Table 3 – DRG to MS-DRG Crosswalk, Effective October 1, 2007

(v24) DRG Prior to 10/01/07	(v25) MS-DRG After 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.0
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Issue Unrelated to the RY 2009 IPF PPS Update

In addition to the aforementioned RY 2009 updates, CMS identified an error within the IPF PPS PRICER that did not calculate a comorbidity adjustment (adjustment factor 1.07) on claims that contained both diagnosis code 07070 and a discharge date occurring on or after January 1, 2005, through June 30, 2006. CR 6077 announces that this error will be corrected in the release of the RY 09 PRICER. Medicare FIs and A/B MACs will reprocess and finalize any claim affected by this error, if you bring it to their attention.

Additional Information

You may find more information about the RY 2009 update to the IPF PPS by going to CR 6077, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1543CP.pdf*.

You will find updated *Medicare Claims Processing Manual* chapter 3 (Inpatient Hospital Billing) sections 190.4.2.1 (Budget Neutrality Components), 190.5 (Patient-Level Adjustments), 190.5.1 (Diagnosis- Related Groups (DRGs) Adjustments), 190.5.2 (Application of Code First, 190.6.5 - Cost-of-Living Adjustment (COLA) for Alaska and Hawaii), 190.7.3 (Electroconvulsive Therapy (ECT) Payment), 190.7.4 (Stop Loss Provision (Transition Period Only)), 190.10.1 (General Rules), and 190.17.1 (Inputs/Outputs to PRICER) as an attachment to CR 6077.

If you have any questions, please contact your to 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: MM6077
Related Change Request (CR) Number: 6077
Related CR Release Date: June 27, 2008
Related CR Transmittal Number: R1543CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008
Source: CMS Pub. 100-04, Transmittal 1543, CR 6077

EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, enacted on July 15, 2008, extends the use of the cost to charge payment methodology for brachytherapy and therapeutic radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the outpatient prospective payment system (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing will be complete by September 30, 2008. ❖

Source: CMS Provider Education Resource 200807-22
CMS JSM 08415, July 16, 2008

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SKILLED NURSING FACILITY SERVICES

DENIAL OF PAYMENT FOR NEW ADMISSIONS FOR SKILLED NURSING FACILITY BILLING

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

PROVIDER TYPES AFFECTED

Skilled nursing facilities (SNFs) impacted by payment ban situations and submitting claims to Medicare contractors (fiscal intermediaries [FIs] and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in SNFs.

IMPACT ON PROVIDERS

This article is based on change request (CR) 6116 and addresses the consequences that occur when the Centers for Medicare & Medicaid Services (CMS) impose sanctions that preclude Medicare payment for new admissions (or denial of payment for new admissions [DPNA]) to a SNF when a facility is not in substantial compliance with Medicare requirements of participation. Be sure billing staff are aware of these instructions, especially the use of occurrence span code 80 on appropriate claims.

BACKGROUND

Under the Social Security Act at sections 1819(h) and 1919(h) and CMS regulations at 42 CFR 488.417, CMS may impose a DPNA against a SNF when a facility is not in substantial compliance with requirements of participation.

Medicare policy indicates that beneficiaries admitted before the effective date of a DPNA situation and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are not considered new admissions, and **are not subject to the denial of payment upon return.**

Medicare instructions previously indicated that SNFs should append a condition code 57 (SNF readmission) for those patients in which the DPNA does not apply.

However, the definition for condition code 57 indicates the patient previously received Medicare covered SNF care within 30 days of this readmission and would not necessarily apply in all payment ban situations.

For example, a readmission could apply to patients that resided in the SNF prior to the imposition of the ban, whether on private pay or covered under another insurer, then went out to a hospital for a qualifying stay and returned directly back to the SNF upon discharge of the hospital. If the patient, in this scenario, did not receive Medicare SNF covered care within 30 days of the readmission then the condition code 57 would not be appropriate.

Therefore, CMS is updating DPNA instructions to require SNF providers to append occurrence span code 80 (definition below), for same-SNF readmissions, to indicate the most recent prior same-SNF stays dates of the patient prior to their discharge to the hospital for a qualifying hospital stay. **As long as the patient resides in the SNF prior to the imposition of a payment ban and the patient discharges to the hospital then directly back to the same SNF from the hospital the claim would be considered a readmission for DPNA purposes and a payment ban will not be applicable.**

In addition, if the patient resides in the SNF prior to the imposition of the ban and goes on a leave of absence (LOA), the patient will not be subject to a ban upon their return to the SNF should a payment ban be applicable during their return. Providers must be sure to bill the LOA period on their claim.

KEY POINTS OF CHANGE REQUEST 6116

Chapter 6, section 50 of the *Medicare Claims Processing Manual* covers SNF payment bans and related DPNA actions. CR 6116 revises that section as follows:

Billing for Admissions Not Covered by the Payment Ban

Effective January 1, 2009, when a SNF that is under a payment ban needs to submit a claim for a Medicare beneficiary readmission that is not subject to the payment ban, the SNF must use **occurrence span code 80 for reporting prior same-SNF stay dates**. The definition of **"**Prior Same-SNF Stay Dates for Payment Ban Purposes" is: **The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.** (Previously, SNFs used condition code 57 for this purpose, but that code does not apply to all payment ban situations.)

Effect on Utilization Days and Benefit Period

In situations where the beneficiary's SNF admission is subject to the payment ban, but the **provider fails to issue the proper beneficiary liability notice, the** benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts from the beneficiary. **These days will be charged against the patient's utilization** as is currently done with other types of technical denials (e.g., late filing, late denial notices to the patient, etc.).

If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

Effect of an Appeal to A DPNA on Billing during the Period the SNF Is Subject to a DPNA

In those situations where the SNF decides to appeal the imposition of a DPNA, it must still bill the program as set forth in the provider liability billing instructions in the revised Section 50, which is attached to CR 6116. In essence, the SNF needs to file a covered bill with the FI or A/B MAC using

Denial of Payment for New Admissions for Skilled Nursing Facility Billing (continued)

occurrence span code 77 that indicates the facility is liable for the services in situations where the SNF failed to issue the proper beneficiary liability notice and any applicable copayments will be charged to the beneficiary's Part A benefit period. In addition, the SNF needs to file a non-payment bill for noncovered Part A services using **condition code 21 that indicates beneficiary liability**. Remember that services that would have been eligible for Part A benefits in the absence of sanctions may not be billed as Part B charges to Medicare.

Conducting Resident Assessments

If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, no payment is made and the SNF must submit a claim using the health insurance prospective payment system (HIPPS) default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

When the SNF does not receive timely notification that a payment ban has been lifted, and staff is unaware of the need to start the Medicare-required schedule (the beneficiary meets all applicable eligibility and coverage requirements), the SNF may bill the Medicare five-day and 14-day assessment using the HIPPS code generated by the 14-day Omnibus Budget Reconciliation Act (OBRA) required assessment. If the SNF did not perform any assessments with an assessment reference date during the assessment window for the Medicare-Required five-day or 14-day assessment, the SNF must bill the default rate for those covered days associated with the assessment. Where the SNF did not perform an assessment with an assessment reference date (ARD) that fell in the applicable Medicare-required assessment window for the 30, 60 and 90-day Medicare-required assessments it shall bill the default rate. If the SNF did perform an assessment, including a significant change in status assessment (SCSA), where the ARD fell in the window of a 30, 60 or 90-day Medicare-required assessment (including grace days), the SNF shall bill using the HIPPS code generated from the assessment in accordance with the payment policies found in chapter 28 of the *Provider Reimbursement Manual.* The date the sanction is lifted is Day ONE for purposes of the Medicare assessment schedule.

Example 1:

The SNF is notified on June 15th that its payment ban was lifted effective June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-required assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the five-day Medicare-required assessment for up to 14 days. Day 15 is day one for purposes of starting the Medicare-required assessment schedule and a five-day Medicare required assessment shall be performed.

Example 2:

The SNF is notified on August 15 that its payment ban was lifted on June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-required assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the five-day Medicare required assessment and the 14-day Medicare required assessment. The 30-day assessment may be billed through day 44 at the default rate. Day 45 is day 1 for purposes of starting the Medicare- required assessment schedule and a five-day Medicare required assessment shall be performed.

Additional Information

For complete details regarding this CR please see the official instruction (CR 6116) issued to your Medicare contractor. Current Medicare instructions for DPNA billing reside in sections 50-50.7 of chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual*. CR 6116 revises these sections and you may review these revised sections in the attachment to this CR 6116 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1555CP.pdf*.

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

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

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Related CR Release Date: July 18, 2008
Related CR Transmittal Number: R1555CP
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Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1555, CR 6116

CORRECT CONDITION CODE TO REPORT ON PROVIDER ADJUSTMENT REQUESTS TO INDICATE HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM CODE CHANGE

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

PROVIDER TYPES AFFECTED

Skilled nursing facilities (SNF), swing bed (SB) providers, inpatient rehabilitation facilities (IRF) and home health agencies (HHA) that bill Medicare fiscal intermediaries (FI) and Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request (CR) 6002, from which this article is taken, announces that, as of January 1, 2009, you should no longer use condition code **D4** to report health insurance prospective payment system (HIPPS) code changes on SNF adjustment requests, but rather should begin to use condition code **D2** – Change in revenue codes/HCPCS/ HIPPS rate codes - instead.

BACKGROUND

Medicare systems have historically required SNF) and swing bed (SB) providers to append condition code **D4** to inpatient adjustment requests when a change is made to the original HIPPS code billed on the claim.

However, because the National Uniform Billing Committee (NUBC) has recently revised the definition for condition code **D4**, to indicate a change in clinical codes (ICD) for diagnosis and/or procedure codes, CR 6002, from which this article is taken, clarifies the correct condition code to report on adjustment requests when changing a previously processed HIPPS code.

Effective January 1, 2009, you should no longer use the D4 condition code to report HIPPS code changes on SNF adjustment requests, but instead should begin to use condition code **D2** – Change in revenue codes/HCPCS/ HIPPS rate codes.

In addition, Medicare systems have been updated to require IRFs and HHs to also report condition code **D2** on adjustment requests that alter the existing HIPPS code on a previous paid claim, effective January 1, 2009.

You should be aware that your FI or A/B MAC **will return adjustment requests** when a claim contains a HIPPS code change without a condition code **D2**.

ADDITIONAL INFORMATION

You may find more information about the correct condition code to report on provider adjustment requests to indicate a health insurance prospective payment system (HIPPS) code change by going to CR 6002, located on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1565CP.pdf*.

You will find updated *Medicare Claims Processing Manual* chapter 6 (SNF Inpatient Part A Billing), sections 30.5 (Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections) and 30.5.1 (Adjustment Requests) as an attachment to CR 6002. In addition you might want to refer to chapter 25, (Completing and Processing the Form CMS-1450 Data Set), on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf*, for further description of the code sets reported on the CMS-1450.

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: MM6002
Related Change Request (CR) Number: 6002
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1565CP
Effective Date January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1565, CR 6002

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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.

CORF SERVICES

EXTENSION OF THERAPY CAP EXCEPTIONS

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. One provision of this legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the modifier **KX** for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1810 for calendar year 2008. For occupational therapy services, the limit is $1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the modifier **KX** will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the modifier **KX** on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the modifier **KX** that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the modifier **KX** so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary. ❖

Source: CMS Provider Education Resource 200807-20
CMS JSM 08411, July 16, 2008

EXCEPTIONS TO THERAPY CAPS ARE RESTRICTED AS OF JULY 1, 2008

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

Note: The Centers for Medicare & Medicaid Services (CMS) has rescinded *MLN Matters* special edition article SE0815 July 17, 2008, since the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, which was enacted on July 15, 2008, has extended the exceptions to the therapy caps. For more details, see *MLN Matters* article SE0826 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0826.pdf*.

The *MLN Matters* special edition article SE0815 was published in the July 2008 *Medicare A Bulletin* (page 53).

MLN Matters Number: SE0815 – Rescinded
Related Change Request (CR) Number: 5871
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0815

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

JULY 2008 INTEGRATED OUTPATIENT CODE EDITOR SPECIFICATIONS VERSION 9.2

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

Note: CMS has revised this *MLN Matters* article on June 21, 2008, to reflect changes made to change request (CR) 6080 on July 18, 2008. CR 6080 was revised to reflect a legislative change that continues the cost-to-charge payment methodology for brachytherapy and therapeutic radiopharmaceuticals through January 1, 2010. This required some adjustments to the table on this article. Also, the CR release date, transmittal number, and the Web address for accessing CR 6080 were revised. All other information remains the same. The *MLN Matters* article MM6080 was published in the July 2008 *Medicare A Bulletin* (pages 54-55).

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article is based on change request (CR) 6080 which provides the integrated outpatient code editor (I/OCE) instructions and specifications for the July, 2008, I/OCE that will be used for processing outpatient prospective payment system (OPPS) and non-OPPS claims from hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health prospective payment system (HH PPS) or to a hospice patient for the treatment of a non-terminal illness.

BACKGROUND

CR 6080 informs providers, FIs and A/B MACs that the I/OCE is updated for July 1, 2008. The I/OCE routes all institutional outpatient claims (which includes non-OPPS through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

Claims with dates of service prior to July 1, 2007, are routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

CR 6080 provides the I/OCE instructions and specifications that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, CMHCs, and for all non-OPPS providers, and for limited services when provided in an HHA not under the HH PPS or to a hospice patient for the treatment of a non-terminal illness. The I/OCE instructions are attached to CR 6080 and will also be posted on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/OutpatientCodeEdit/*.

CR 6080 also includes as an attachment with detailed lists of the ambulatory payment classifications (APC), Health Care Common Procedure Coding System (HCPCS), and *Current Procedural Terminology (CPT)* code changes, additions, and deletions. This article will not repeat all of those changes. However, the key modifications of the OCE for the July 2008 release (V9.2) are summarized in the following table.

In the table note that:

- Highlighted sections indicate change from the prior release of the software.
- Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

July 2008 Integrated Outpatient Code Editor Specifications Version 9.2 (continued)

Effective Date	Edit	Summary of Change
7/1/08	24	Modify the software to maintain/retain 28 prior quarters (seven years) of programs and codes in each release. Remove older versions with each release. (The earliest version date included in the July 2008 release will be 4/1/01).
7/1/08	50	Change disposition for edit 50 to **RTP (Return to Provider).** **Note: The IOCE change to RTP this claim will no longer trigger an initial determination. The provider should bill statutorily excluded services as noncovered and affix liability with the GY modifier (beneficiary liable).**
4/1/01		Exclude denied or rejected lines from PHP (partial hospitalization program) processing and from daily mental health assignment criteria.
		Make HCPCS/APC/SI changes as specified by CMS
	19, 20, 39, 40	Implement version **14.1** of the NCCI (National Correct Coding Initiative) file, removing all code pairs which include anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
1/1/08	17	Remove codes 92621 and 92627 from the Inherently bilateral list – change bilateral indicator to '0'.
7/1/08	15	Change all max units to zero for all codes that currently have max unit values other than zero.
1/1/08	78	Update nuclear medicine/radiopharmaceutical edit requirements.
7/1/08	71/77	**Update procedure/device edit requirements.**
7/1/08	22	**Add new modified CG ("Policy criteria applied") to the valid modifier list.**
		Documented some 'general programming notes' that were in effect but not previously documented.
		Documented the exclusion of denied or reject lines from composite criteria.
1/1/08	78	Implement mid-quarter NCD activation date for specified G codes and apply to G0398, G0399 and G0400 if 'Date of Service" is before 3/13/08.
		Create a 508 compliant version of the document (modify as necessary) – for publication on CMS Web site.

ADDITIONAL INFORMATION

The official instruction, CR 6080, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1560CP.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 Website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM6080 – Revised
Related Change Request (CR) Number: 6080
Related CR Release Date: July 18, 2008
Related CR Transmittal Number: R1560CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1560, CR 6080

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

WHAT YOU NEED TO KNOW

Change request (CR) 6090, from which this article is taken, reminds providers of the periodic updates to the claim status codes and claim status category codes that Medicare contractors use with the health care claim status request (ASC X12N 276), and the health care claim response (ASC X12N 277).

BACKGROUND

The claim category and claim status codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only National Code Maintenance Committee-approved codes in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1).

The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6090, from which this article is taken, updates the changes in the claim status codes and claim status category codes from the February 2008 committee meeting, which were posted at *http://www.wpc-edi.com/content/view/180/223/* on February 29, 2008 (previously referenced by *http://www.wpc-edi.com/codes*). CR 6090 reminds Medicare contractors that they must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by its implementation date (October 6, 2008). On and after this date, these code changes are to be used in editing of all X12 276 transactions processed, and to be reflected in the X12 277 transactions issued.

ADDITIONAL INFORMATION

You may find the official instruction, CR 6090, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1533CP.pdf* on the CMS Web site

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

MLN Matters Number: MM6090
Related Change Request (CR) Number: 6090
Related CR Release Date: June 13, 2008
Related CR Transmittal Number: R1533CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1533, CR 6090

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EDUCATIONAL EVENTS

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

MAY 2008 – SEPTEMBER 2008

Ask the Contractor – Topics: Community Mental Health Center/Psychiatric Partial Hospitalization Program

When: Tuesday, August 12, 2008
Time: 11:30 a.m. – 1:00 p.m. Eastern Standard Time
Type of Event: Teleconference/Webcast

Recovery Audit Contractor (RAC) – Topics: RAC Permanent Program

When: Wednesday, August 20, 2008
Time: 11:30 a.m. – 1:00 p.m. Eastern Standard Time
Type of Event: Webcast – Live Encore

Hot Topics – Medicare Updates

When: Tuesday, September 9, 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. ❖

OTHER EDUCATIONAL RESOURCES

MEDICARE GUIDE TO RURAL HEALTH SERVICES

The print version of the revised *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians* (April 2008) is now available from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network.* This guide contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005.

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

Source: CMS Provider Education Resource 200807-08

REVISED RURAL REFERRAL CENTER FACT SHEET

The *Revised Rural Referral Center Fact Sheet* (April 2008), which provides information about the rural referral center program requirements, is now available in print format from the Centers for Medicare & Medicaid Services (CMS) *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 200807-07

CRITICAL ACCESS HOSPITAL FACT SHEET NOW AVAILABLE

The *Critical Access Hospital Fact Sheet* is now available in print format from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*. This fact sheet provides information about:

- Eligible critical access hospital (CAH) providers
- CAH designation
- CAH payments
- Reasonable cost payment principles that do not apply to CAHs
- Election of standard method or optional (elective) payment method
- Medicare rural pass-through funding for certain anesthesia services
- Health professional shortage area Incentive payments
- Physician scarcity area bonus payments
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Grants to states under the Medicare rural hospital flexibility program.

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 200807-15

RURAL HEALTH CLINIC FACT SHEET

The April 2008 version of *the Rural Health Clinic Fact Sheet* provides the following information about rural health clinic services:

- Medicare certification
- Visits
- Payments
- Cost reports
- Annual reconciliation

This fact sheet is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network* in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralHlthClinfctsht08.pdf*. If this hyperlink does not take you directly to the fact sheet, please copy and paste the URL into your Internet browser. ❖

Source: CMS Provider Education Resource 200807-13

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Addresses

CLAIMS STATUS
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

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

MEDICARE SECONDARY PAYER (MSP)
Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

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

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

PROVIDER EDUCATION
Medicare Outreach and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

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

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1-904-791-6865

Help Desk (Confirmation/Transmission)
1-904-905-8880

Medicare Web sites

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

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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