

MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

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

Publications issued after October 1, 1997, are available at no-cost from our provider

Web site at www.fcso.com.

Routing Suggestions :

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



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

**Medicare Publications
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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.medicare.fcsocom>.

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 May 2008 *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 QPU 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

Three national coverage determinations issued to protect patients from preventable surgical errors

The Centers for Medicare & Medicaid Services (CMS) recently announced three national coverage determinations (NCDs) to establish uniform national policies that will prevent Medicare from paying for certain serious, preventable errors in medical care. The following errors, called “never events,” specified in these NCDs are identified in the national quality forum’s (NQF) list of serious reportable events:

- Wrong surgical or other invasive procedures performed on a patient.
- Surgical or other invasive procedures performed on the wrong body part.
- Surgical or other invasive procedures performed on the wrong patient.

In addition, consistent with current policy for noncovered services, Medicare does not cover any services related to these noncovered services.

In 2002, prompted in part by the release of the 1999 Institute of Medicine report titled, *To Err is Human: Building a Safer Health System*, the NQF created a list of 27 never events, which was expanded to 28 events in 2006. As part of the ongoing implementation of Section 5001(c) of the Deficit Reduction Act (DRA) of 2005, CMS has addressed some of the NQF list of never events through the hospital-acquired conditions (HACs) provisions in the inpatient prospective payment system (IPPS) final rule for fiscal years (FY) 2008 and 2009.

For discharges occurring on or after Oct. 1, 2008, Medicare will no longer pay a hospital at a higher rate for an inpatient hospital stay if the sole reason for the enhanced payment is one of the selected HACs, and the condition was acquired during the hospital stay. CMS is exploring the feasibility of adapting this policy to its other payment systems.

In the IPPS FY 2008 final rule, CMS selected eight categories of conditions for the HAC list, a number of which were among the 28 never events listed by the NQF and include retained foreign object after surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, and injuries related to falls and traumatic events such as electric shock and burns.

In the IPPS FY 2009 final rule, CMS added manifestations of poor glycemic control, including hypoglycemic coma, to the list. Hypoglycemic coma is closely related to NQF’s listing of death or serious disability associated with hypoglycemia.

CMS determined that not all conditions included on the NQF list of never events should be addressed by the HAC payment provision and therefore determined that the NCD process was appropriate to address coverage for the three types of surgical errors cited above. Unlike the HAC provisions, which affect only payments to hospitals for inpatient stays, these NCDs may affect payment to hospitals, physicians, and any other health care providers and suppliers involved in the erroneous surgeries.

These NCDs are effective immediately; however, implementation instructions for processing such claims will occur at a later date. To view the NCDs, visit:

Wrong body part: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222>.

Wrong patient: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221>.

Wrong surgery performed on a patient: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=223&> ❖

Source: CMS PERL 200901-28

Flu shot reminder

It’s not too late to get the flu shot. We are in the midst of flu season, and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. Re-vaccination is necessary each year because flu viruses change each year. So please encourage your Medicare patients who haven’t already done so to get their annual flu shot. Don’t forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends.

Get your flu shot -- not the flu!

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

Health care professionals and their staff can learn more about Medicare’s coverage of the influenza vaccine and other Medicare Part B covered vaccines and related provider education resources created by the CMS *Medicare Learning Network (MLN)*, by reviewing special edition *MLN Matters* article SE0838 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf> on the CMS Web site. ❖

Source: CMS PERL 200901-05

Institutional 837 submissions may have not crossed to supplemental insurers correctly

The Centers for Medicare & Medicaid Services (CMS) is alerting you that many of the institutional claims (not specific to any bill type) submitted to your designated A/B Medicare administrative contractor (MAC) or fiscal intermediary (FI) near to/around December 1, 2008, may not have automatically crossed over to your patients' supplemental insurers.

As the result of a systems error within the Part A shared system that arose with the installation of a systems fix on December 1, 2008, several hundred thousand 837 institutional claims were not crossed over successfully through the national coordination of benefits agreement (COBA) crossover process. The problem related to missing required taxonomy code elements (PRV01 and PRV02) at the 2000A PRV level. Please note that, as of December 18, 2008, the Part A shared system fixed all further incidence of the taxonomy code problems. Therefore, as of that date, all claims sent to the COB contractor (COBC) for national crossover purposes will no longer contain the earlier problem.

Important: As of December 30, 2008, the Part A shared system is making a claim repair job available to all affiliate A/B MACs or FIs. Upon installation of the claim repair job, the A/B MACs or FIs will repair all previously claims processed incorrectly and will retransmit them to the COBC for crossover purposes. CMS encourages all institutional providers to not balance the bills for their patients' supplemental insurers for any claims they believe may not have crossed over during December 1st through 18th and to allow an additional two to three weeks from this notification before attempting to bill their patients' supplemental insurance. ❖

Source: CMS PERL 200812-46

Reporting withholding due to IRS federal payment levy program on the remittance advice

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

Note: CMS has revised this *MLN Matters* to add information regarding requirements for provider representatives who contact IRS and to make other minor clarifications. This *MLN Matters* article 6125 was published in the September 2008 *Medicare A Bulletin* (page 7).

Provider types affected

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

Provider action needed

STOP – impact to you

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

CAUTION – what you need to know

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

GO – what you need to do

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

Background

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

The Centers for Medicare & Medicaid Services (CMS) may reduce your Medicare payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, CMS will notify the payee in the remittance advice which federal payment was levied, the amount withheld, and the toll free IRS/Treasury telephone number the payee should contact for resolution. If the amount of the withholding through FPLP exceeds the total debt owed by the payee, the IRS/Treasury is responsible for refunding the overpayment to the payee.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of "WU" in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field and the amount of the withholding will be inserted in the PLB04 field. **Please note that under current privacy rules and regulations, only the IRS/Treasury may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.**

The person contacting the IRS must be authorized to represent the provider/physician regarding tax matters, otherwise the IRS will not discuss the issue. The caller must also have the taxpayer identification number (TIN) of the provider/physician from whom the recovery was made. The person calling the IRS should also state that the recovery was from a Medicare payment.

Reporting withholding due to IRS federal payment levy program on the remittance advice (continued)

Please be advised that it can take several days for the amount offset from the Medicare payment to be posted to the IRS records.

If you use Medicare Remit Easy Print (MREP) software supplied by your Medicare contractor, you had to obtain an updated version of the software, on or after October 6, 2008, in order to view these changes on your printed remittances.

Additional information

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

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

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

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New workload numbers for Medicare administrative contractor jurisdiction 9

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

Provider types affected

Physicians, providers, and suppliers in the state of Florida and territories of Puerto Rico and the Virgin Islands submitting claims to 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) 6285, which announces that the Centers for Medicare & Medicaid Services (CMS) will issue new workload numbers to replace the existing contractor numbers for the Medicare administrative contractor jurisdiction 9 ((MAC J9) Part A and Part B workloads in the state of Florida and the territories of Puerto Rico and the Virgin Islands. These changes are being made because certain CMS claims systems rely on these numbers for processing purposes. Some provider systems may also rely on these numbers.

Background

The workloads to be transitioned, effective dates and new numbers are indicated in the following tables:

Part A workload

Location	MAC workload number	Effective date	Current contractor Number
Florida	09101	February 16, 2009	00090
Puerto Rico	09201	March 2, 2009	57400
U. S. Virgin Islands	09201	March 2, 2009	00468

Part B workload

Location	MAC workload number	Effective date	Current contractor Number
Florida	09102	February 2, 2009	00590
Puerto Rico	09202	March 2, 2009	00973
U.S. Virgin Islands	09302	March 2, 2009	00974

The Florida Part A and Part B workloads are currently processed by:

First Coast Service Options Inc.
 (Blue Cross and Blue Shield of Florida, Inc.)
 532 Riverside Avenue
 Jacksonville, Florida 32202-4914

The Puerto Rico and United States Virgin Islands Part A workload is currently processed by:

Cooperativa de Seguros de Vida de Puerto Rico
 GPO Box 363428
 San Juan, Puerto Rico 00936-3428

*New workload numbers for Medicare administrative contractor jurisdiction 9 (continued)***The Puerto Rico/Virgin Islands Part B workload is currently processed by:**

Triple-S, Inc.
Box 71391
San Juan, Puerto Rico 00936-1391

In the event the MAC transition needs to be delayed, CMS will provide as much notice as possible to affected Medicare contractors, but no less than five business days prior to the planned effective date.

Finally, CMS is studying how best to transition to the applicable MACs the workload covered by contractor workload number 52280, which was formerly processed by Mutual of Omaha and is currently processed by Wisconsin Physicians Service (WPS). CMS will notify all parties concerned as soon as its instructions are finalized for that transition.

Additional information

The official instruction, CR 6285, issued regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R423OTN.pdf> on the CMS Web site.

If you have any questions, please contact your carrier or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6285 Revised
Related Change Request (CR) Number: 6285
Related CR Release Date: December 24, 2008
Related CR Transmittal Number: R423OTN
Effective Date: February 2, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 423, CR 6285

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Efforts to reduce Medicare waste, fraud, and abuse**Medicare issues final rule requiring surety bonds for DMEPOS suppliers and takes next step in fighting home health fraud**

The Centers for Medicare & Medicaid Services (CMS) announced it is requiring certain durable medical equipment suppliers to post a surety bond. In addition, CMS announced that it has revoked the billing privileges of more than 1,100 medical equipment suppliers in south Florida and southern California and is suspending payments to Florida home health agencies in the Miami-Dade area.

To view the entire press release dated December 29, 2008, go to the following link on the CMS Web site at http://www.cms.hhs.gov/apps/media/press_releases.asp. ❖

Source: CMS PERL 200901-03

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

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

Note: This information was previously published in the September 2008 *Medicare A Bulletin* (pages 5-6).

Provider types affected

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

What you need to know

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

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

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

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious nonmedical health care institutions paid under Part A; were instructed to use the general ABN-G or ABN-L to inform beneficiaries of their potential liability

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

in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

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

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

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

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare fee-for-service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious nonmedical health care institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).

2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and notice of exclusion from Medicare benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

Note: Once the revised skilled nursing facility (SNF) ABN is implemented, SNFs must use the revised SNF ABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:

- Care is not reasonable and necessary
- There was a violation of the prohibition on unsolicited telephone contacts
- Medical equipment and supplies supplier number requirements not met
- Medical equipment and/or supplies denied in advance
- Custodial care
- A hospice patient who is not terminally ill.

4. In the following situations ABN use is voluntary. ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification). Additionally, the ABN may also be issued voluntarily in place of the NEMB for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act.
- Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
 - ♦ Services for which there is no legal obligation to pay
 - ♦ Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles)
 - ♦ Services required as a result of war
 - ♦ Personal comfort items
 - ♦ Routine physicals (except the initial preventive physical or “Welcome to Medicare” physical examination) and most screening tests
 - ♦ Routine eye care
 - ♦ Dental care
 - ♦ Routine foot care

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

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

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

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations;

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

the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and comprehensive outpatient rehabilitation facility (CORF).

Additional information

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

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

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

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6136

Related Change Request (CR) Number: 6136

Related CR Release Date: September 5, 2008

Related CR Transmittal Number: R1587CP

Effective Date: March 3, 2008

Implementation Date: March 1, 2009

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

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

2009 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

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

Provider types affected

Clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Impact on providers

This article is based on change request (CR) 6070 which provides instructions for the calendar year (CY) 2009 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

Background

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet), as amended by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (Section 628), the annual update to the local clinical laboratory fee schedule for Calendar Year (CY) 2009 is 4.5 percent. Payments made on a reasonable charge basis for all other laboratory services are updated by 5.0 percent. The Social Security Act (Section 1833(a)(1)(D)) provides that payment for a clinical laboratory test is the lesser of the following:

- The actual charge billed for the test
- The local fee, or
- The national limitation amount (NLA).

For a cervical or vaginal smear test (Pap smear), the Social Security Act (Section 1833(h)(7)) requires payment

to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge.

Note The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2009 national minimum payment amount is \$15.42 (\$14.76 plus 4.5 percent update for CY 2009). The affected CPT/HCPCS codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National limitation amounts (maximum)

For tests for which national limitation amounts (NLAs) were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with the Social Security Act (Section 1833(h)(4)(B)(viii)).

2009 annual update for clinical laboratory fee schedule and laboratory services... (continued)

Access to data file

Internet access to the CY 2009 clinical laboratory fee schedule data file is available after November 17, 2008, on the CMS Web site at <http://www.cms.hhs.gov/ClinicalLabFeeSched>.

Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2009 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 14, 2008, CMS hosted a public meeting to solicit input on the payment relationship between CY 2008 codes and new CY 2009 *Current Procedural Terminology (CPT)* codes. Notice of the meeting was published in the *Federal Register* on May 23, 2008, and on the CMS Web site on June 16, 2008. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site. Additional written comments from the public will be accepted until October 10, 2008. CMS will post a summary of the public comments and the rationale for their final payment determinations on the CMS Web site also.

Pricing information

The CY 2009 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (*CPT/HCPCS* codes 36415, P9612, and P9615).

For dates of service from January 1, 2009, through December 31, 2009, the fee for clinical laboratory travel code P9603 is \$1.035 per mile (rounded to \$1.04 if necessary) and the fee for clinical laboratory travel code P9604 is \$10.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2009, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2009 clinical laboratory fee schedule also includes codes that have modifier “QW” to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the CY 2009 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping information

- New code 83876 is priced at the same rate as code 83520.
- New code 83951 is priced by adding the rates for code 83950.

- New code 85397 is priced at the same rate as code 85245.
- New code 87905 is priced by subtracting the rate for code 87176 from the rate for code 82657.
- New code 88720 is priced at the same rate as code 88400.
- New code 88740 is priced at the same rate as code 88400.
- New code 88741 is priced at the same rate as code 88400.
- Code 88400 is deleted beginning CY 2009.
- Healthcare Common Procedure Coding System (HCPCS) code G0394 is deleted beginning CY 2009.
- For CY 2009, there are no new test codes to be gap filled.

Laboratory costs subject to reasonable charge payment in CY 2009

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 through 42 CFR 405.508 (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html on the Internet), the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by the Social Security Act (Section 1842(b)(3); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) and 42 CFR 405.509(b)(1) (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html on the Internet). Further, Section 145 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adjusted the inflation-indexed update by -0.5 percent. As a result, the inflation-indexed update for CY 2009 is 4.5 percent.

Manual instructions for determining the reasonable charge payment may be found in Publication 100-04, *Medicare Claims Processing Manual* (Chapter 23, Section 80 through 80.8; see on the CMS Web site <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>). If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual* (Chapter 8, Section 60.3; see on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>) instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044

2009 annual update for clinical laboratory fee schedule and laboratory services... (continued)

P9050 P9051 P9052 P9053 P9054 P9055 P9056
P9057 P9058 P9059 P9060

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual* (Chapter 3, Section 20.5 through 20.54; see on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>) (formerly *Medicare Carriers Manual* (MCM) 2455):

P9010 P9016 P9021 P9022 P9038 P9039 P9040
P9051 P9054 P9056 P9057 P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on the Social Security Act (Section 1842(o)). The payment limits based on that provision, including the payment limits for codes P9041, P9043, P9045, P9046, P9047, P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine

86850 86860 86870 86880 86885 86886 86890
86891 86900 86901 86903 86904 86905 86906
86920 86921 86922 86923 86927 86930 86931
86932 86945 86950 86960 86965 86970 86971
86972 86975 86976 86977 86978 86985 G0267

Reproductive medicine procedures

89250 89251 89253 89254 89255 89257 89258
89259 89260 89261 89264 89268 89272 89280
89281 89290 89291 89335 89342 89343 89344
89346 89352 89353 89354 89356

Additional information

The official instruction, CR 6070, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1660CP.pdf> on the CMS Web site.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6070

Related Change Request (CR) Number: 6070

Related CR Release Date: December 31, 2008

Related CR Transmittal Number: R1660CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1660, CR 6070

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January 2009 quarterly average sale price Medicare Part B drug pricing file updates and previous file revisions

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

Provider types affected

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

What you need to know

Change request (CR) 6288, from which this article is taken, instructs Medicare contractors to download and implement the January 2009 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2008, July 2008, April 2008, and January 2008 files. They will use the January 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2009 with dates of service January 1, 2009, through March 31, 2009.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or

prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

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

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

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

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

January 2009 quarterly ASP Medicare Part B drug pricing file updates and previous file revisions (continued)

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

ASP methodology

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

- End-stage renal disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities).
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS).
- Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP five percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP four percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

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

- The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP; but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of \$0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2009, the blood clotting furnishing factor of \$0.164 per I.U. is added.**

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

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

January 2009 quarterly ASP Medicare Part B drug pricing file updates and previous file revisions (continued)**Quarterly payment files**

On or after December 16, 2008, the January 2009 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after December 16, 2008, the January 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6288 for the dates of service noted in the following table:

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

Drugs furnished during filling or refilling an implantable pump or reservoir

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

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

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

Payment allowance limit revision date	Applicable dates of service
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008

Additional information

You may find the official instruction, CR 6288, issued to your carrier, FI, RHHI, MAC, or DME MAC by visiting on the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1650CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6288

Related Change Request (CR) Number: 6288

Related CR Release Date: December 19, 2008

Related CR Transmittal Number: R1650CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1650, CR 6288

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New common working file Medicare secondary payer type for Workers' Compensation Medicare set-aside arrangements to stop conditional payments

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

Provider types affected

Physician, providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services related to Workers' Compensation liability claims

What you need to know

In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare contractors with instructions on the creation of a new Medicare secondary payer (MSP) code in Medicare's claim processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) will have the capability to discontinue conditional payments for diagnosis codes related to such settlements.

Background

A workers' compensation Medicare set-aside arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates its common working file (CWF) system in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit the CMS Web site at <http://www.cms.hhs.gov/WorkersCompAgencyServices>.

The CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or

services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, your Medicare contractor will notify the beneficiary using Medicare summary notice (MSN) message 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies).

In addition, Medicare will use reason code 201, group code PR, and remark code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence. Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with "EB" followed by the qualifier WC.

Additional information

You may find the official instruction, CR 5371, issued to your Medicare contractor on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1665CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM5371
Related Change Request (CR) #: 5371
Related CR Release Date: January 9, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1665CP
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1665, CR 5371

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2009 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD for Florida is available on the FCSO Medicare Web site at: <http://medicare.fcso.com/MEDPARD/>. ❖

Source: CMS Pub. 100-04, Transmittal 1627, CR 6235

Emergency update to the 2009 Medicare physician fee schedule database

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [A/B MACs])for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6351 which amends payment files that were issued to contractors based upon the 2009 MPFS final rule. Be sure billing staff are aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physician' services.

Specific changes included in the Emergency Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6351. That CR is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1661CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site. Key changes, however, are summarized as follows:

Key changes

Noncovered services

Due to the national coverage determination for thermal intradiscal procedures (TIPs), effective September 29, 2008, current procedural terminology (CPT) codes 22526, 22527, 0962T, and 0963T became noncovered services on or after September 29, 2008, for Medicare purposes.

Descriptor changes

The long and/or short descriptors have been revised for the following codes:

CPT code	Revised long descriptor	Revised Short Descriptor
4275F	Hepatitis B vaccine injection administered or previously received (HIV)	Hep b vac inj admin/ rcvd
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	N/A
D1203	Topical application of fluoride – child	Topical app fluoride child
D1204	Topical application of fluoride – adult	Topical app fluoride adult
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	End thxpy, anterior tooth
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	End thxpy, bicuspid tooth
D3330	Endodontic therapy, molar (excluding final restoration)	End thxpy, molar
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	N/A
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	N/A
D4240	Gingival flap procedure, including root planning – four or more contiguous teeth or tooth bounded spaces per quadrant	N/A
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant	N/A
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	N/A
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	N/A
Q4114	Integra flowable wound matrix, injectable, 1 cc	N/A

*Emergency update to the 2009 Medicare physician fee schedule database (continued)***New dental codes for 2009**

Code	Long descriptor	Short Descriptor
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Collect & prep saliva sample
D0418	Analysis of saliva sample	Analysis of saliva sample
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	Part pulp for apexogenesis
D5991	Topical medicament carrier	Topical medicament carrier

Additional information

The official instruction, CR 6351, issued to your carrier, FI, or MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1661CP.pdf>.

If you have any questions, please contact your carrier, FI, or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6351

Related Change Request (CR) Number: 6351

Related CR Release Date: January 2, 2009

Related CR Transmittal Number: R1661CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1661, CR 6351

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Shipboard services billed to Medicare not provided within the United States

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6217 which announces that the Centers for Medicare & Medicaid Services (CMS) wants providers to know that the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* are being revised. Chapter 1, Section 10.1.4.7 of the *Medicare Claims Processing Manual* currently states that services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry and that the physician must be registered with the Coast Guard in order for Medicare to make payment. However, Section 10.1.4.7 of the manual is not consistent with Medicare law. Therefore, because Section 10.1.4.7 of the manual is not consistent with Medicare law, CMS is clarifying that manual section in order to make it consistent with current Medicare law by removing the language that states the vessels must be of American registry and the physician must be registered with the Coast Guard.

CMS is also clarifying in the manual that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered. CMS removed the term “and during a period of” covered foreign hospitalization since it implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the beneficiary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services are covered both during the time period immediately before the beneficiary is actually admitted to the foreign hospital and during the covered foreign hospitalization itself. In other words, if the foreign hospitalization is covered by Medicare, then the emergency physician and ambulance services that are furnished during the time period that immediately precedes the covered foreign hospitalization are also covered. Be sure your billing staff is aware of these changes.

Key points of change request 6217

The following services furnished aboard a vessel are covered:

- Emergency and nonemergency services furnished by a physician or supplier aboard a vessel are covered when the ship is within the territorial waters of the United

Shipboard services billed to Medicare not provided within the United States (continued)

States. If the emergency or nonemergency services were furnished within the territorial waters of the United States and the physician or supplier refuses to submit the claim on the beneficiary's behalf (or enroll in Medicare, if applicable), then the contractor must follow the compliance monitoring instructions outlined in the *Medicare Claims Processing Manual*, chapter 1, section 70.8.8.6B because these claims are not processed as foreign claims. Chapter 1 of the *Medicare Claims Processing Manual* may be reviewed on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.

- Emergency services furnished by a physician or supplier aboard a vessel are covered when the services are rendered while the ship is within the territorial waters of Canada (while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another state) and the emergency services are furnished in connection with a covered foreign hospitalization in Canada. The compliance monitoring instructions outlined in the *Medicare Claims Processing Manual*, Chapter 1, Section 70.8.8.6B do not apply to these claims because they are processed as foreign claims.
- See Chapter 1 Section 10.1.4 of the *Medicare Claims Processing Manual* for the definitions of "territorial waters" and "United States."
- Your Medicare contractors/carriers will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization.

Background

Medicare law (i.e., Section 1862(a)(4) of the Social Security Act) prohibits payment for items and services furnished outside the United States except for certain limited services (see Section 1814(f) of the Act). The term "United States" means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States.

The law specifies the following exceptions to the "foreign" exclusion:

1. Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
 - a. the emergency arose within the U.S.; or
 - b. the emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another state.
2. Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists.
3. Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Additional information

To see the official instruction (CR 6217) issued to your Medicare FI, carrier or A/B MAC visit the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1609CP.pdf>.

The second transmittal, covering the revisions to the Medicare Benefit Policy Manual, is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R95BP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6217

Related Change Request (CR) Number: 6217

Related CR Release Date: October 3, 2008

Related CR Transmittal Number: R1609CP and R95BP

Effective Date: January 5, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1609, CR 6217

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Providers urged to participate in annual Medicare contractor satisfaction survey

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

Provider types affected

Medicare physicians, providers, and suppliers selected to participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS).

Provider action needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) will distribute its annual MCPSS to a new sample of Medicare providers. CMS is sending the 2009 survey, designed to be completed in about 20 minutes, to approximately 30,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. CMS will begin to notify providers selected to participate in the survey in December 2008. Providers are urged to submit their responses via a secure Web site, mail, fax, or over the telephone.

Background

The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. All Medicare administrative contractors (MACs) will be measured against performance targets on the 2009 MCPSS as part of their contract requirements.

The 2008 survey results revealed that, for the second consecutive year, the top indicator of satisfaction among providers was how Medicare contractors handled provider inquiries. As in the two previous years, claims processing also remained a strong indicator in 2008 of provider satisfaction across all contractor types. The shift from claims processing as the top predictor in 2006 to provider inquiries as the top predictor of satisfaction in 2008 is an example of the type of trend data the MCPSS will reveal. Contractors are able to factor such insights into how they prioritize their provider-focused efforts.

Feedback captured through MCPSS is important, and CMS urges all Medicare providers who are selected to participate in the MCPSS to complete and return their surveys upon receipt. CMS plans to analyze the 2009 MCPSS data and release a summary report at <http://www.cms.hhs.gov/MCPSS> on the CMS Web site in July 2009.

Key points

- Survey questions focus on seven business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

- Respondents are asked to rate their contractors using the 1 to 6 scale on each of the business functions with "1" representing "not at all satisfied" and "6" representing "completely satisfied." Contractors receive an overall composite score as well as a score on each business function.
- Results from previous surveys have enabled CMS to set performance standards for MAC's.
- Performance standards give contractors a benchmark to use to compare themselves to other contractors, as well as an individual standard to improve upon year after year.
- The contractor's MCPSS score is based on the average survey score from all surveyed Medicare providers in the contractor's jurisdiction. To meet the performance standard, the MAC's score for the 2009 MCPSS must fall within a specified range of the 2008 national mean score. The average 2008 MCPSS for all contractors, released last August, was 4.51 on a scale of 1 to 6. This score was comparable to the 2007 average MCPSS score of 4.56. CMS plans to utilize MCPSS results to help structure future contract incentives.

The MCPSS is required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Specifically, the law calls for CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to the Medicare fee-for-service program.

Additional information

For further information, visit <http://www.cms.hhs.gov/MCPSS> on the CMS Web site. 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: SE0843
 Related Change Request (CR) Number: N/A
 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 SE0843

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Clarification of Medicare payment for routine costs in a clinical trial

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

Note: CMS has revised this MLN Matters article to delete the first question and answer. All other information remains the same. This information was previously published in the October 2008 *Medicare A Bulletin* (pages 10-11).

Provider types affected

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

Provider action needed

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

Background

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

40 No Legal Obligation to Pay for or Provide Services

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free X-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

Key points of special edition article SE0822

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

Question #1: If the research sponsor pays for the routine costs provided to an indigent non-Medicare patient (the provider has determined that the patient is indigent due to a valid financial hardship) may Medicare payment be made for Medicare beneficiaries?

Answer #1: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the

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

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

Question #2: May a research sponsor pay Medicare copays for beneficiaries in a clinical trial.

Answer #2: If a research sponsor offers to pay cost-sharing amounts owed by the beneficiary, this could be a fraud and abuse problem. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a federal health care program.

The citations include 42 U.S.C. 1320a-7(a)(i)(6); OIG Special Advisory Bulletin on Offering Gifts to Beneficiaries (<http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>) and OIG Special Fraud Alert on Routine Waivers of Copayments and Deductibles (<http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>).

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

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

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

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

MLN Matters Number: SE0822

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0822

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Update to the e-prescribing incentive program

Beginning January 1, 2009, eligible professionals can participate in the e-Prescribing incentive program by reporting on their adoption and use of an e-prescribing system by submitting information on one e-prescribing measure on their Medicare Part B claims. For the 2009 e-prescribing reporting year, to be a successful e-prescriber and to qualify to receive an incentive payment, an eligible professional must report one e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the eligible professional during 2009. There is no sign-up or pre-registration to participate in the e-Prescribing incentive program. For more information, visit <http://www.cms.hhs.gov/PQRI> and select *e-Prescribing Incentive Program* in the left-hand column.

In October 2008, the Centers for Medicare & Medicaid Services (CMS) and 34 partner organizations hosted a meeting about the mechanics of implementing an e-prescribing program in a practice. Audiotapes and slides are now archived online for continuing education credit. The Massachusetts Medical Society and the American Pharmacist Association are pleased to provide continuing medical education (a maximum of 22.5 AMA PRA Category 1 Credits™, [risk management study for MA physicians] and continuing education for pharmacists (up to 13.25 hours of continuing education credit [1.325 CEUs]). Simply go to http://www.massmed.org/cme/CMS_eprescribing to view the presentations and hear the audiotapes of the program. There are no registration or certificate fees. ❖

Source: CMS PERL 200901-27

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 (three percent for calendar year 2009) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR has been changed to **11.375 percent, effective January 23, 2009**. The PCR will remain in effect until a new rate change is published. Below is a list of previous interest rates.

Period	Interest rate
October 22, 2008 – January 22, 2009	11.375 %
July 24, 2008 – October 21, 2008	11.125%
April 18, 2008 – July 23, 2008	11.375%
January 18, 2008 – April 17, 2008	12.125%
October 19, 2007 – January 17, 2007	12.5%
July 20, 2007 – October 18, 2007	12.625%
April 20, 2007 – July 19, 2007	12.375%
January 19, 2007 – April 19, 2007	12.5%. ❖

Source: CMS Pub. 100-06, Transmittal 146, CR 6239

Signature and date stamps for DME supplies-certificates of medical necessity and DME MAC information forms

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

Provider types affected

Providers and suppliers submitting claims, certificates of medical necessity (CMN), or durable medical equipment Medicare administrative contractor information forms (DDIFs) to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) related to durable medical equipment, prosthetic, and orthotic supplies (DMEPOS) provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6261 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. Signature and date stamps are not acceptable for use on CMNs and DIFs. Be sure your billing staffs are aware of this change. Your Medicare contractors will accept only hand written, facsimiles of original written and electronic signatures and dates on medical record documentation for medical review purposes on CMNs and DIFs.

Background

CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for durable medical equipment, prosthetic, and orthotic supplies (DMEPOS) have been met. The *Program Integrity Manual (PIM)*, Chapter 3, section 3.4.1.1, which may be reviewed on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf> states that Medicare requires

a legible identifier for services provided/ordered. The method used should be hand written including facsimiles of original written or an electronic signature in accordance with Chapter 3, Section 3.4.1.1 to sign an order or other medical record documentation for medical review purposes. Signature and date stamps are not acceptable for use on CMNs and DIFs.

Additional information

For complete details regarding this change request (CR) please see the official instruction (CR 6261) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R281PI.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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6261

Related Change Request (CR) Number: 6261

Related CR Release Date: December 31, 2008

Related CR Transmittal Number: R281PI

Effective Date: February 2, 2009

Implementation Date: February 2, 2009

Source: CMS Pub. 100-08, Transmittal 281, CR 6261

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Medicare DMEPOS competitive bidding program announcements

The Centers for Medicare & Medicaid Services (CMS) has announced that an interim final rule with comment period, which implements certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the Round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive acquisition program, is on display at the *Federal Register*.

CMS has also announced the appointment of new members to serve on the Program Advisory and Oversight Committee (PAOC) for the DMEPOS competitive bidding program.

Visit the CMS Web site at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/> to view the list of PAOC members and for the latest information on the DMEPOS competitive bidding program.

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

Source: CMS PERL 200901-23

Changes in payment for oxygen equipment and additional instructions regarding payment for durable medical equipment prosthetics orthotics and supplies

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6297 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) terminates all **round I supplier contracts awarded under the DMEPOS Competitive Bidding program**, as a result of Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which delays the program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts. This article also provides guidance on the changes in payment for oxygen and oxygen equipment as a result of section 144(b) of the MIPPA of 2008, as well as, additional claims processing and payment instructions for DMEPOS items. See the *Key points* of this article for specific instructions that impact you.

Background

Oxygen and oxygen equipment are paid on a fee schedule basis in accordance with section 1834(a)(5) of the Social Security Act. The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use, after which the equipment title transferred to the beneficiary. As part of the DRA rulemaking effort, CMS established beneficiary safeguards to ensure that suppliers would continue to maintain and service beneficiary-owned oxygen equipment after the 36-month cap. The safeguards included payment for periodic (every six months) general maintenance and servicing of beneficiary-owned oxygen equipment, payment for pickup of beneficiary-owned oxygen tanks that are no longer needed, and rules for furnishing or replacing oxygen equipment during the 36-month payment period.

MIPPA was enacted on July 15, 2008. Section 144(b) of the MIPPA repeals the transfer of ownership provision established by the DRA for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. This one-time update provides guidance on the changes in payment for oxygen and oxygen equipment resulting from Section 144(b) of the MIPPA. CR 6297 also contains additional claims processing and payment instructions for DMEPOS. Specific instructions related to the implementation of these changes will be issued in a separate CR (CR 6296). Once CR 6296 is released, a related *MLN Matters* article will be available on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf>.

Key points

Payment policies for oxygen and oxygen equipment and capped rental following the enactment of the MIPPA of 2008

- Section 154 of the MIPPA delays the Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Competitive Bidding Program and terminates all round I supplier contracts. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts.
- Medicare will pay no more than 13 continuous rental months for capped rental items and 36 continuous monthly payment amounts for oxygen and oxygen equipment.
- The competitive bidding policy that would have provided an additional 13 months of rental payments in situations where beneficiaries transitioned from noncontract suppliers to contract suppliers in the middle of the 13-month rental period for capped rental items is no longer valid. Therefore, for capped rental items, the supplier who received payment for the 13th continuous rental month must transfer title of the equipment to the beneficiary.
- The competitive bidding policy that would have provided a minimum of 10 monthly payments to contract suppliers in situations where beneficiaries transitioned from noncontract suppliers to contract suppliers in the middle of the 36-month rental period for oxygen and oxygen equipment is no longer valid. Therefore, for oxygen and oxygen equipment, the supplier who receives payment for the 36th continuous rental month must continue to furnish the oxygen and oxygen equipment until the reasonable useful lifetime of the oxygen equipment expires.
- Beneficiaries residing in the 10 competitive bidding areas for round I may obtain oxygen and oxygen equipment and capped rental items and supplies from any Medicare-enrolled supplier and are not required to return to the supplier they were using before July 1, 2008.

New HCPCS modifiers for repair and replacement

- The following two modifiers are being added to the HCPCS on January 1, 2009, and are effective for claims with dates of service on or after January 1, 2009:

RA – Replacement of a DME item

RB – Replacement of a part of DME furnished as part of a repair

- The existing modifier RP was deleted from the HCPCS, effective December 31, 2008.

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

- Suppliers should use the new modifier RA on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. In contrast, the new modifier RB should be used on a DMEPOS claim to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).
- Medicare contractors will accept modifier “RA” rather than “RP” for replacement of beneficiary-owned DMEPOS due to loss, irreparable damage, or when the item has been stolen.
- Medicare contractors will accept modifier “RB” rather than “RP” for replacement parts furnished in order to repair beneficiary-owned DMEPOS.

Additional instructions for implementation of MIPPA 144(b) – oxygen equipment

- Section 144(b) of the MIPPA eliminates the requirement for suppliers to transfer title to oxygen equipment to the beneficiary following the 36th continuous month during which payment is made for the equipment. The requirement for suppliers to transfer title to the beneficiary for capped rental equipment following the 13th continuous month during which payment is made for the equipment remains in effect. As noted above, section 144(b) of MIPPA repealed the Deficit Reduction Act (DRA) transfer of title provision for oxygen equipment and allows suppliers to retain ownership of the oxygen equipment following the 36-month rental cap.
- The supplier who furnished the stationary and/or portable oxygen equipment during the 36-month rental period is required to continue furnishing the stationary and/or portable equipment following the 36-month rental period for any period of medical need for the remainder of the equipment’s reasonable useful lifetime.
- The supplier who receives payment for furnishing the equipment during month 36 of continuous use is responsible for furnishing the oxygen equipment at any time after the 36-month rental period and before the expiration of the reasonable useful lifetime of the oxygen equipment if the beneficiary has a medical need for oxygen and oxygen equipment furnished under Medicare Part B. This requirement includes situations where there is a temporary break in need or break in use of the equipment of any duration after the 36-month rental cap. In such situations, the supplier remains responsible for furnishing the oxygen equipment after the break in need for the remainder of the reasonable useful lifetime during which the medical need for oxygen and oxygen equipment continues.
- Following the 36-month cap, the supplier is responsible for furnishing all of the same necessary services associated with furnishing oxygen equipment that were furnished during the 36-month rental period. For example, as required by the Medicare quality standards for respiratory equipment, supplies, and services established in accordance with 1834(a)(20)

of the Social Security Act, the supplier shall provide services 24 hours a day, seven days a week as needed by the beneficiary. Suppliers may not bill beneficiaries separately for these services.

- Medicare oxygen equipment rental payments continue to be limited to 36 months and under no circumstances will a new rental period start following the completion of the 36-month rental period unless the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful lifetime expires.
- As indicated in section 30.6 of Chapter 20 of the *Medicare Claims Processing Manual* (Pub. 100-04), the monthly payment amount for oxygen and oxygen equipment covers equipment, contents, supplies and accessories. Section 144(b) of MIPPA caps the all inclusive oxygen and oxygen equipment monthly payments at 36 months and does not provide for payment of replacement oxygen supplies and accessories following the 36-month cap. The supplier who received payment for furnishing the oxygen and oxygen equipment during the 36-month rental period is responsible for continuing to furnish any accessories and supplies necessary for the effective use of the equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Therefore, separate payment shall not be made for replacement of supplies and accessories for use with oxygen equipment that are furnished on or after January 1, 2009. This applies to any supply or accessory billed under a miscellaneous HCPCS code, any codes added to the HCPCS in the future, or under the following current HCPCS codes:

HCPCS Code	Descriptor
A4608	Transtracheal oxygen catheter, each
A4615	Cannula, nasal
A4616	Tubing (oxygen), per foot
A4617	Mouth piece
A4619	Face tent
A4620	Variable concentration mask
A7525	Tracheostomy mask, each
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator
E1354	Wheeled cart for portable cylinder or concentrator (Added to HCPCS effective January 1, 2009)
E1355	Stand/rack
E1356	Battery pack/cartridge for portable concentrator (Added to HCPCS effective January 1, 2009)
E1357	Battery charger for portable concentrator (Added to HCPCS effective January 1, 2009)
E1358	DC power adapter for portable concentrator (Added to HCPCS effective January 1, 2009)

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

- Instructions regarding claims for oxygen accessory or supply codes will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional instructions for implementation of MIPPA 144(b) – oxygen contents

- Section 144(b) of MIPPA also mandates that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment.
- Monthly payment for oxygen contents for beneficiary-owned liquid or gaseous oxygen equipment (stationary or portable) shall continue to be made in accordance with existing program instructions in section 30.6.3 of Chapter 20 of the *Medicare Claims Processing Manual*, which is available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site. Suppliers should continue to use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents.
- Separate payment shall not be made under any circumstances for the pick up and disposal of liquid or gaseous oxygen equipment (i.e., tanks).
- Instructions regarding claims for oxygen contents will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional instructions for implementation of MIPPA 144(b) – maintenance and servicing of oxygen equipment

Section 144(b) of MIPPA mandates payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap. The 36-month cap applies to stationary and portable oxygen equipment furnished on or after January 1, 2006; therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006. CMS has determined that under no circumstances would it be reasonable and necessary to pay for any maintenance and servicing or repair of supplier-owned oxygen equipment, with the exception of an in-home visit by suppliers to inspect oxygen concentrators and transfilling equipment and provide general maintenance and servicing six months after the 36-month rental cap.

Additional claims processing and payment instructions regarding these maintenance and servicing visits will be furnished in a separate CR.

- In the case of all oxygen equipment furnished after the 36-month rental cap, the supplier is responsible for performing any repairs or maintenance and servicing

of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime of the equipment. This includes parts that must be replaced in order for the supplier-owned equipment to continue to function appropriately.

- Payment shall not be made for any repairs or maintenance and servicing, other than the maintenance and servicing payments described above. In no case shall payment be made for any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.
- Payment shall not be made for loaner equipment furnished during periods when these repairs or maintenance and servicing services are performed.

Payment for capped rental equipment following the enactment of MIPPA

As noted above, MIPPA of 2008 did not eliminate or amend the provisions of the DRA of 2005 that apply to capped rental DME. All previously issued Medicare instructions relating to these provisions remain in effect, including the requirement for suppliers to transfer title of the equipment on the first day after the 13th continuous month of use during which payment is made for the equipment.

MIPPA remittance advice messages

Although Section 144(b) of the MIPAA takes effect on January 1, 2009, the new remittance advice (RA) and Medicare summary notice (MSN) messages associated with this provision are not yet available. Therefore, in the interim, for claims with dates of service of January 1, 2009 and later, the following non-specific RA message will be used when paying the 36th month oxygen equipment claim:

Reason code 223: Adjustment code for mandated federal, state or local law/legislation that is not already covered by another code and is mandated before a new code can be created.

Additional instructions related to the implementation of this provision of the MIPPA will be provided in the near future.

Revisions to the labor payment rates associated with repairing DMEPOS items

- As part of this update, CMS is revising the labor payment rates for HCPCS code(s) E1340, L4205, and L7520. The current rates were established based on historic supplier charges; however, annual inflation adjustments were not applied consistently from state to state. In addition, the rates differ dramatically among the states in the continental United States (e.g., from \$9.51 to \$23.53 in the case of E1340). To reduce this span and correct the disparity in payments for codes E1340, L4205, and L7520, CMS is revising the fees to apply inflation updates in years where it determined that these updates were not provided. Secondly, state payment amounts below the median state payment amount are being increased to the median state payment amount for each code. These changes are effective for claims with dates of service on or after January 1, 2009.

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

- Attachment A (see *Additional information* section of this article) contains the revised 2009 payment amounts for HCPCS codes E1340, L4205, and L7520. The payment rates include all costs (other than replacement of parts) associated with repairing DMEPOS items.
- Suppliers should only bill in 15 minutes for the time spent repairing the item and cannot bill for the time spent traveling to the beneficiary's home.
- The rates established for codes E1340, L4205, and L7520 are based on 25 percent of the previous hourly repair rates for codes E1350, L4200, and L7500, respectively. The supplier's travel costs are assumed to have been taken into account by suppliers in setting the prices they charged for these services under these codes. As such, these costs have already been accounted for in the calculation of the rates for codes E1340, L4205, and L7520. Therefore, separate payment shall not be made for travel costs associated with repairing DMEPOS items. In addition, suppliers may not bill beneficiaries directly for travel charges.
- DME MACs, RHHIs and Medicare carriers and/or MACs will use the 2009 allowed payment amounts for code E1340 under Attachment A (see *Additional information* section of this article) to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned DME with dates of service from January 1, 2009, through December 31, 2009.
- DME MACs, FIs, Medicare carriers and/or MACs will use the 2009 allowed payment amounts for codes L4205 and L7520 under Attachment A to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned orthotics, prosthetics, and prosthetic devices with dates of service from January 1, 2009, through December 31, 2009.

Medicare coverage of elastic support garments

CMS has received questions regarding coverage of elastic support garments such as leg, arm, back, or neck braces (orthotics). The definition of a brace in section 130 of Chapter 15 of the *Medicare Benefit Policy Manual* specifies that:

A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace.

Elastic garments or devices in general do not meet the definition of a brace because they are not rigid or semi-rigid devices. This includes devices that include stays that do not provide sufficient pressure to restrict or eliminate motion in the body part. While elastic devices may provide compression or warmth to a leg, arm, back, or neck, if they do not restrict or eliminate motion in a diseased or injured part of the body, then they may not be covered as braces. When a Medicare contractor identifies an elastic device that does not meet the Medicare definition of a brace, they shall not cover claims submitted for these devices and they shall not classify such devices under a HCPCS code that describes items that do meet the Medicare definition of a brace.

Additional information

For complete details regarding this CR please see the official instruction (CR 6297) issued to your Medicare FI, RHHI, DME/MAC, or A/B MAC. That instruction may be viewed on the CMS Web site by going to <http://www.cms.hhs.gov/Transmittals/downloads/R421OTN.pdf>.

For more information on CR 5461, you may go to on the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf>.

The related *MLN Matters* article may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5461.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6297

Related Change Request (CR) Number: 6297

Related CR Release Date: December 23, 2008

Related CR Transmittal Number: R421OTN

Effective Date: January 1, 2009

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GENERAL INFORMATION

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

Attachment A

2009 repair and service fees, 15 minute unit

State	E1340	L4205	L7520
AK	23.59	28.79	33.88
AL	24.71	19.99	27.14
AR	24.71	19.99	27.14
AZ	22.40	19.97	33.39
CA	22.40	32.83	38.26
CO	22.40	19.99	27.14
CT	19.95	20.45	27.14
DC	19.95	19.97	27.14
DE	19.22	9.97	27.14
FL	17.46	19.99	27.14
GA	18.10	19.99	27.14
HI	15.61	28.79	33.88
IA	15.49	19.97	32.49
ID	15.49	19.97	27.14
IL	13.41	19.97	27.14
IN	13.41	19.97	27.14
KS	13.41	19.97	33.88
KY	13.41	25.60	34.71
LA	13.41	19.99	27.14
MA	15.32	19.97	27.14
MD	13.41	19.97	27.14
ME	13.41	19.97	27.14
MI	13.41	19.97	27.14
MN	13.41	19.97	27.14
MO	13.41	19.97	27.14
MS	13.41	19.99	27.14
MT	13.41	19.97	33.88

State	E1340	L4205	L7520
NC	13.41	19.99	27.14
ND	13.41	28.73	33.88
NE	13.41	19.97	37.84
NH	13.41	19.97	27.14
NJ	15.99	19.97	27.14
NM	14.00	19.99	27.14
NV	14.40	19.97	36.99
NY	14.40	19.99	27.14
OH	14.40	19.97	27.14
OK	13.41	19.99	27.14
OR	13.41	19.97	39.03
PA	13.41	20.56	27.14
PR	13.41	19.99	27.14
RI	13.41	20.58	27.14
SC	13.41	19.99	27.14
SD	13.41	19.97	36.28
TN	13.41	19.99	27.14
TX	13.41	19.99	27.14
UT	13.41	19.97	42.27
VA	13.41	19.97	27.14
VI	13.41	19.99	27.14
VT	13.41	19.97	27.14
WA	13.41	29.30	34.80
WI	13.41	19.97	27.14
WV	13.41	19.97	27.14
WY	13.41	26.65	37.84

Source: CMS Pub. 100-20, Transmittal 421, CR 6297

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GENERAL COVERAGE

Correction to prothrombin time monitoring for home anticoagulation management

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs] or Medicare administrative contractors [MACs]) for home prothrombin time (PT) and international normalized ratio (INR) anticoagulation management monitoring services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6313, which corrects CR 6138 (Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management, released on July 25, 2008) by adding particular ICD-9-CM codes (451.11, 451.19, 451.2, 451.80-451.84, 451.89, 453.40-453.49 and 415.12) that CR 6138 omitted. It contains no other changes; however its content is repeated in this article for your convenience as a reference document.

CR 6313 alerts providers that effective for claims with dates of service on and after March 19, 2008, the Centers for Medicare & Medicaid Services (CMS) revised its national coverage determination (NCD) on PT/INR monitoring for home anticoagulation management to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. Effective March 19, 2008, Medicare now covers the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with 1) mechanical heart valves, 2) chronic atrial fibrillation and 3) venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

Background

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

In response to a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin, the Centers for Medicare & Medicaid Services (CMS) revised its NCD on PT/INR monitoring for home anticoagulation management.

Effective for claims with dates of service on and after March 19, 2008, Medicare will cover the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

This coverage includes the following ICD-9-CM codes.

ICD-9-CM code descriptor

- V43.3 Organ or tissue replaced by other means; heart valve
- 289.81 Primary hypercoagulable state
- 451.0 Phlebitis and thrombophlebitis: of superficial vessels of lower extremities: saphenous vein (greater) (lesser)
- 451.11 Phlebitis and thrombophlebitis: of deep vessels of lower extremities: femoral vein (deep) (superficial)
- 451.19 Phlebitis and thrombophlebitis: of deep vessels of lower extremities: other (femoropopliteal vein popliteal vein tibial vein)
- 451.2 Phlebitis and thrombophlebitis: of deep vessels of lower extremities: other (femoropopliteal vein, popliteal vein, tibial vein)
- 451.80 Phlebitis and thrombophlebitis: of other sites
- 451.81 Phlebitis and thrombophlebitis: of other sites: iliac vein
- 451.82 Phlebitis and thrombophlebitis: of other sites: of superficial veins of upper extremities (antecubital vein, basilic vein, cephalic vein)
- 451.83 Phlebitis and thrombophlebitis: of other sites: of deep veins of upper extremities (brachial vein, radial vein, ulnar vein)
- 451.84 Phlebitis and thrombophlebitis: of other sites: of upper extremities, unspecified
- 451.89 Phlebitis and thrombophlebitis: of other sites: other
- 451.9 Phlebitis and thrombophlebitis: of other sites: of unspecified site
- 453.0 Other venous embolism and thrombosis: Budd-Chiari Syndrome (hepatic vein thrombosis)
- 453.1 Other venous embolism and thrombosis: thrombophlebitis migrans
- 453.2 Other venous embolism and thrombosis: of vena cava
- 453.3 Other venous embolism and thrombosis: of renal vein
- 453.40 Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of unspecified vessels of lower extremity (deep vein thrombosis NOS, DVT NOS)
- 453.41 Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of deep vessels of proximal lower extremity (femoral, iliac, popliteal; thigh, upper leg NOS)
- 453.42 Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of deep vessels of distal lower extremity (calf, lower leg NOS; peroneal, tibial)

Correction to prothrombin time monitoring for home anticoagulation management (continued)

- 453.8 Venous embolism and thrombosis of deep vessels of lower extremity: of other specified veins
- 453.9 Venous embolism and thrombosis of deep vessels of lower extremity: of unspecified site
- 415.11 Pulmonary embolism and infarction: iatrogenic pulmonary embolism and infarction
- 415.12 Pulmonary embolism and infarction: septic pulmonary embolism
- 415.19 Pulmonary embolism and infarction: other
- 427.31 Atrial fibrillation (established) (paroxysmal)

You should keep in mind that the monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See on the CMS Web site http://www.cms.hhs.gov/ClinicalLabFee Sched/downloads/410_32.pdf.) and all of the following requirements must be met:

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

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

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

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

Short descriptor G0248: Demonstrate use home INR mon.

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

Short descriptor G0249: Provide INR test mater/equipm.

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

Short descriptor G0250: MD INR test revie inter mgmt.

Notes:

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

Your Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with this CR; however denied claims are subject to appeal, and medical review override of denials for appeal purposes will be allowed. When denying such claims, your Medicare carrier, FI or MAC will use the following codes:

- Medicare summary notice 15.20, “The following policies (NCD 190.11) were used when we made this decision.”
- Remittance advice remark code N386, “This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available on the CMS Web site at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- Claim adjustment reason code 50, “These are noncovered services because this is not deemed a ‘medical necessity’ by the payer.”

Your Medicare contractor will adjust claims already processed and inappropriately denied prior to the implementation of CR 6313, but only if you bring such claims to the attention of the contractor.

Additional information

You may find more information about PT/INR monitoring for home anticoagulation management by going to CR 6313, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1663CP.pdf>.

The revised *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 60 (Coverage and Billing for Home Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management), Subsections 4.1 (Allowable Covered

Correction to prothrombin time monitoring for home anticoagulation management (continued)

Diagnosis Codes) and 5.2 (Applicable Diagnosis Codes for Carriers) may be found as an attachment to that CR.

If you have any questions, please contact your carrier, FI, or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6313

Related Change Request (CR) Number: 6313

Related CR Release Date: January 8, 2009

Related CR Transmittal Number: R1663CP

Effective Date: March 19, 2008

Implementation Date: February 9, 2009

Source: CMS Pub. 100-04, Transmittal 1663, CR 6313

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Prothrombin time monitoring for home anticoagulation management

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 change request 6138 and replaced with CR 6313. CR 6313 reflects additional ICD-9-CM codes involved with this home prothrombin time monitoring for home anticoagulation management. Those codes were inadvertently omitted from CR 6138. Please see *MLN Matters* article MM6313 being published in this issue of the *Medicare A Bulletin*. MM6313 is also available on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6313.pdf>. *MLN Matters* MM6138 was previously published in the September 2008 *Medicare A Bulletin* (pages 39-40).

MLN Matters Number: MM6138 – Rescinded

Related Change Request (CR) Number: 6138

Related CR Release Date: July 25, 2008

Related CR Transmittal Number: R1562CP and R90NCD

Effective Date: March 19, 2008

Implementation Date: August 25, 2008

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

Negative pressure wound therapy devices

The Centers for Medicare and Medicaid Services (CMS) have partnered with the Agency for Healthcare Research and Quality (AHRQ) to commission a review of negative pressure wound therapy (NPWT) devices. The purpose of this review is to provide information to CMS for consideration in Healthcare Common Procedure Coding System (HCPCS) coding decisions. Section 154(c) (3) of the Medicare Improvements for Patient and Providers Act of 2008 (MIPPA) calls for the Secretary of Health and Human Services to perform an evaluation of the HCPCS codes for NPWT devices.

The HCPCS Level II coding system is a comprehensive, standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing.

Devices are classified based on similarities in function and whether one product exhibits significant therapeutic distinctions from other products. This review will facilitate CMS' evaluation of HCPCS coding for NPWT by providing CMS with relevant studies and information for use in consideration of coding changes, as required by the MIPPA legislation. CMS will use this review in its assessment of whether existing HCPCS codes adequately represent the technology and comparative benefits of NPWT devices.

This review is one of several that are being conducted for the AHRQ Technology Assessment Program. It will include a review of all available literature on the topic and a solicitation from all interested stakeholders including healthcare professionals, scientific researchers, wound care organizations, biotech industry, and the patient wound care community for studies and other compelling clinical evidence regarding clinical outcomes associated with NPWT devices. We are particularly interested in those well-conducted clinical trials that describe the comparative benefits of these devices.

The solicitation for studies and evidence was made available to industry stakeholders on December 30, 2008, and requested stakeholders provide this information to AHRQ by February 06, 2009. Stakeholders who would like to provide information about studies or other compelling evidence related to comparative benefits and outcomes of NPWT devices should refer to <http://www.ahrq.gov/clinic/ta/npwtrequest.htm>.

For the full HCPCS Web page, see the CMS Web site <http://www.cms.hhs.gov/medhpcsgeninfo/>. ❖

Source: CMS PERL 200901-14

Expansion of Medicare telehealth services

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

Provider types affected

Physicians, hospitals, and critical access hospitals (CAHs) submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries.

Provider action needed

In the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC), the Centers for Medicare & Medicaid Services (CMS) added three codes to the list of Medicare distant site health services for follow-up inpatient telehealth consultations. This article highlights the related policy instructions. Be sure your billing staff is aware of these changes.

Background

CMS added three follow-up inpatient telehealth consultations to the list of Medicare distant site health services as noted in the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC). CMS created these new Healthcare Common Procedure Coding System (HCPCS) codes specific to the telehealth delivery of follow up inpatient consultations to re-establish the ability for practitioners to provide and bill for follow up inpatient consultations delivered via telehealth. These procedure codes are for follow-up inpatient telehealth consultations effective January 1, 2009. These new codes are intended for use by practitioners serving beneficiaries located at qualifying originating sites requiring the consultative input of physicians who are not available for a face-to-face encounter. These HCPCS codes are not intended to include the ongoing evaluation and management (E/M) services of a hospital inpatient.

The new HCPCS codes are listed in the following table:

HCPCS Code Descriptor

G0406	Follow-up inpatient telehealth consultation, limited
G0407	Follow-up inpatient telehealth consultation, intermediate
G0408	Follow-up inpatient telehealth consultation, complex

Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to complete an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in person or via telehealth.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies would be included as well, consistent with the nature of the problem(s) and the patient's needs.

The physician or practitioner who furnishes the inpatient follow up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record

or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow up inpatient consultation and is not appropriate for delivery via telehealth. Follow-up inpatient telehealth consultations are subject to the criteria for consultation services, as described in Chapter 12, Section 30.6.10 of the *Medicare Claims Processing Manual*. Medicare manuals are available on the CMS Web site. at <http://www.cms.hhs.gov/manuals/IOM/list.asp>

Payment for follow up telehealth inpatient consultations would include all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim lab work) and communicating with other professionals or family members. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional E/M service could be billed for work related to a follow up inpatient telehealth consultation.

Follow up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS G0406 (Follow-up inpatient telehealth consultation, limited). At this level of service, practitioners would typically spend 15 minutes communicating with the patient via telehealth.
- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS G0407 (Follow-up inpatient telehealth consultation, intermediate). At this level of service, practitioners would typically spend 25 minutes communicating with the patient via telehealth.
- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS G0408 (Follow-up inpatient telehealth consultation, complex). At this level of service, practitioners would typically spend 35 minutes or more communicating with the patient via telehealth.

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with either modifier "GT" or "GQ" to identify the telehealth technology used to provide the service. (For more information on the use of these modifiers see Chapter 12, Section 190.6 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>.)

Expansion of Medicare telehealth services (continued)

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 270) on the CMS Web site at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>, and the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 12, Section 190) at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>.

Additional information

The official instruction, CR 6130, was issued in two transmittals to your carrier, FI, and A/B MAC. The first transmittal revises the *Medicare Benefit Policy Manual* and is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R99BP.pdf> and the second transmittal, which modifies the *Medicare Claims Processing Manual*, is at <http://www.cms.hhs.gov/Transmittals/downloads/R1654CP.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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6130

Related Change Request (CR) Number: 6130

Related CR Release Date: December 24, 2008

Related CR Transmittal Number: R1654CP and R99BP

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Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1654, CR 6130

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Summary of policies in the 2009 Medicare physician fee schedule and the telehealth originating site facility fee

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

Provider types affected

Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries and paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6349 which provides a summary of the policies in the 2009 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2009.

The Social Security Act (Section 1834(m) at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year

by the percentage increase in the Medicare economic index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for calendar year (CY) 2009 is 1.6 percent. The telehealth originating site facility fee for 2009 is 80 percent of the lesser of the actual charge or \$23.72.

Summary of key changes

A complete summary of significant issues discussed in CMS-1403-FC, Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2009; E-prescribing exemption for computer-generated facsimile transmissions; payment for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is attached to CR 6349, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R419OTN.pdf>.

The following further summarizes the key points of that attachment to CR 6349.

Medicare physician fee schedule issues

Payment for preadministration-related services for intravenous infusion of immune globulin (IVIG) Payment is no longer made under the physician fee schedule for G0332, for preadministration related services for IVIG infusion, effective January 1, 2009. This code has been deleted from the MPFS database and is no longer recognized for services furnished after December 31, 2008.

Multiple procedure payment reduction for diagnostic imaging

CMS added several additional procedures to the MPPR list. Six procedures represent codes newly created since

Summary of policies in the 2009 MPFS and the telehealth originating site facility fee (continued)

the MPPR list was established. Four additional procedures were identified as similar to procedures currently subject to the MPPR. CMS also removed CPT code 76778, a deleted code, from the list.

Proposed HCPCS code for prostate saturation biopsies

Prostate saturation biopsy is a technique that was previously described by category III CPT code 0137T, *Biopsy, prostate, needle, saturation sampling for prostate mapping*. Typically, this service entails 40-80 core samples taken from the prostate under general anesthesia. Currently, the biopsies are reviewed by a pathologist and this service is captured under CPT code 88305, *surgical pathology, gross and microscopic examination*, which is separately billed by the physician for each core sample taken. CPT code 88305 has a physician work value of 0.75 and a total nonfacility payment rate of \$102.83. CMS added four G codes to more accurately represent the pathologic evaluation, interpretation, and report for this service. In the final rule with comment period, CMS finalized its proposal, but provided assigned values to the four new G codes based upon assumption of the number of cancerous cells.

New and revised codes

CMS received work relative value unit (RVU) recommendations for 128 new and revised CPT codes from the American Medical Association (AMA) Relative Update Committee (RUC) this year. Of the recommendations received, CMS accepted 114 and disagreed with 14.

The CPT editorial panel created 20 CPT codes to replace the G codes for monthly and per diem end-stage renal disease (ESRD) services. CMS accepted the AMA RUC recommendations for these services. The new CPT codes are listed in the following table:

Deleted G code	New CPT code	Short descriptor
G0308	90951	Esrd serv, 4 visits p mo, <2
G0309	90952	Esrd serv, 2-3 vsts p mo, <2
G0310	90953	Esrd serv, 1 visit p mo, <2
G0311	90954	Esrd serv, 4 vsts p mo, 2-11
G0312	90955	Esrd srv 2-3 vsts p mo, 2-11
G0313	90956	Esrd srv, 1 visit p mo, 2-11
G0314	90957	Esrd srv, 4 vsts p mo, 12-19
G0315	90958	Esrd srv 2-3 vsts p mo 12-19
G0316	90959	Esrd serv, 1 vst p mo, 12-19
G0317	90960	Esrd srv, 4 visits p mo, 20+
G0318	90961	Esrd srv, 2-3 vsts p mo, 20+
G0319	90962	Esrd serv, 1 visit p mo, 20+
G0320	90963	Esrd home pt, serv p mo, <2
G0321	90964	Esrd home pt serv p mo, 2-11
G0322	90965	Esrd home pt serv p mo 12-19

Deleted G code	New CPT code	Short descriptor
G0323	90966	Esrd home pt, serv p mo, 20+
G0324	90967	Esrd home pt serv p day, <2
G0325	90968	Esrd home pt srv p day, 2-11
G0326	90969	Esrd home pt srv p day 12-19
G0327	90970	Esrd home pt serv p day, 20+

Renumbered CPT codes

Effective for CY 2009, the following CPT codes have been renumbered:

Deleted CPT code	New CPT code	Short descriptor
90760	96360	Hydration iv infusion, init
90761	96361	Hydrate iv infusion, add-on
90765	96365	Ther/proph/diag iv inf, init
90766	96366	Ther/proph/diag iv inf addon
90767	96367	Tx/proph/dg addl seq iv inf
90768	96368	Ther/diag concurrent inf
90769	96369	Sc ther infusion, up to 1 hr
90770	96370	Sc ther infusion, addl hr
90771	96371	Sc ther infusion, reset pump
90772	96372	Ther/proph/diag inj, sc/im
90773	96373	Ther/proph/diag inj, ia
90774	96374	Ther/proph/diag inj, iv push
90775	96375	Tx/pro/dx inj new drug addon
90776	96376	Tx/pro/dx inj new drug adon
90779	96379	Ther/prop/diag inj/inf proc
99289	99466	Ped crit care transport
99290	99467	Ped crit care transport addl
99293	99471	Ped critical care, initial
99294	99472	Ped critical care, subsq
99295	99468	Neonate crit care, initial
99296	99469	Neonate crit care, subsq
99298	99478	Ic, lbw inf < 1500 gm subsq
99299	99479	Ic lbw inf 1500-2500 g subsq
99300	99480	Ic inf pbw 2501-5000 g subsq
99431	99460	Init nb em per day, hosp
99432	99461	Init nb em per day, non-fac
99433	99462	Sbsq nb em per day, hosp
99435	99463	Same day nb discharge
99436	99464	Attendance at delivery
99440	99465	Nb resuscitation

*Summary of policies in the 2009 MPFS and the telehealth originating site facility fee (continued)***Medicare telehealth services**

CMS has added HCPCS codes specific to follow-up inpatient consultation delivered via telehealth and clarified that the criteria for these services will be consistent with Medicare policy for consultation services.

For 2009, Medicare contractors will pay for the Medicare telehealth originating site facility fee as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014 at 80 percent of the lesser of the actual charge or \$23.72. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Part B drug issues

In the 2009 MPFS final rule, CMS announces it will adopt three regulatory changes affecting payment of Part B drugs under the average sales price (ASP) methodology, i.e.:

- CMS will update its regulations to comport with the new volume-weighting ASP calculation methodology established in section 112(a) of the Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2008.
- CMS will make conforming changes to its regulations to address the special payment rule for certain single source drugs or biologicals that are treated as multiple source drugs because of the application of the grandfathering provisions of section 1847A of the Act.
- Section 1847A(d)(1) of the Act allows the Secretary to disregard the ASP for a Part B drug or biological that exceeds the WAMP or the AMP for such drug by an applicable threshold percentage. For CY 2009, CMS will maintain the threshold at five percent, absent of data that suggests a change is appropriate.

Application of health professional shortage area (HPSA) bonus payment

CMS makes minor policy revisions to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of ZIP codes for automated HPSA bonus payments should use the modifier AQ to receive the HPSA bonus payment.

Independent diagnostic testing facilities (IDTF)

CMS is requiring all mobile units providing diagnostic testing services to Medicare beneficiaries to enroll in the Medicare program. In addition, all mobile units furnishing diagnostic testing services will be required to bill for services unless the service is furnished under arrangement with a hospital. When services are furnished under arrangement, the hospital will continue to bill for the diagnostic testing services.

Physician and nonphysician enrollment safeguards

The following is a summary of the enrollment provisions in the MPFS final rule for 2009:

1. Limit retrospective payments to physicians and nonphysician practitioners (NPPs) and physician and NPP organizations.

CMS has established that the effective date of billing for physicians and NPPs and physician or NPP organizations as the later of: (1) the date of filing of a

Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or NPP first started rendering services at a new practice location. This provision permits physicians and NPPs to retrospectively bill for services furnished up to 30 days prior to the effective date of enrollment if the physician or NPP meets all program requirements, even if the initial enrollment application is rejected or denied as long as the application is ultimately approved. In addition, physicians and nonphysician practitioners will be permitted to retrospectively bill for services furnished up to 90 days prior to the effective date if the physician or NPP meets all program requirements and there is a presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Section 5121-5206 (Stafford Act).

2. Prohibit physicians and NPPs, as well as owners, authorized officials, and delegated officials of a physician or nonphysician practitioner organization from obtaining additional billing privileges if their current billing privileges are suspended or an overpayment is pending.
3. Require all providers and suppliers, including individual practitioners, to maintain ordering and referring documentation for seven years from the date of service.
4. Require physician and nonphysician organizations, physicians and NPPs, and IDTFs to submit all outstanding claims within 60 days of the revocation date.
5. Require physicians and NPPs and physician and NPP organizations to notify their Medicare contractor of a change of ownership, final adverse action, or change of location that impacts a payment amount within 30 days. Failure to notify the designated contractor of these changes may result in an overpayment from the date of the reportable change.

Educational requirements for nurse practitioners (NPs) and clinical nurse specialists (CNSs)

In the 2009 MPFS final rule, CMS finalizes its proposal to recognize the doctor of nursing practice (DNP) degree and also states that it will continue to study the evolution of the DNP degree to ensure that it continues to be consistent with our program requirements. In addition, CMS finalized a proposed technical correction to the NP regulatory qualifications that will clarify that the requirement for a master's degree in nursing is the minimum educational level for newly enrolled NPs and CNSs independently treating Medicare beneficiaries.

Provisions from the Medicare Improvements for Patients and Providers Act of 2008**Section 101: Improvements to Coverage of Preventive Services Payment for the IPPE**

The Medicare Modernization Act of 2003 (MMA) provided for one initial preventive physical examination (IPPE) per beneficiary per lifetime. A beneficiary is eligible when first enrolling in Medicare Part B on or after January

Summary of policies in the 2009 MPFS and the telehealth originating site facility fee (continued)

1, 2005, and receives the IPPE benefit within the first 6 months of the effective date of the initial Part B coverage period. If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate existing HCPCS G code(s). MIPPA made several changes to the IPPE including expanding the IPPE benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B. (Other changes to this benefit were included in segment 1 of the rule.) The following is a summary of the payment changes resulting from section 101 of the MIPPA:

The deductible change with MIPPA

The Medicare deductible does not apply to the IPPE if performed on or after January 1, 2009 within the beneficiary's 12-month initial enrollment period of Medicare Part B. The waived deductible is applicable to the IPPE service only. Medicare will pay for one IPPE per beneficiary per lifetime. The Medicare deductible for the IPPE performed before January 1, 2009 (G0344) applies. Coinsurance applies irrespective of codes or date of the IPPE. The waived deductible for the IPPE, effective January 1, 2009, does not apply to the screening EKG.

New G codes needed with MIPPA implementation

CMS revised the G codes for the IPPE and EKG to reflect the changes in the legislation. The EKG codes will reflect a once-in-a-lifetime screening with a referral from an IPPE.

Section 132: Incentives for Electronic Prescribing

Eligible professionals who are successful electronic prescribers shall be paid 2 percent incentive of estimated allowable charges submitted not later than two months after the end of the reporting period for 2009 successful electronic prescribing.

A "successful electronic prescriber" is defined under section 1848(m)(3)(B)(ii) of the Social Security Act as an eligible professional who reports the e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the professional. Although the Secretary is given authority to assess successful electronic prescribing using either data reported by eligible professionals using electronic prescribing quality measures or using Part D prescription data, CMS will use the former for 2009. CMS will set forth the statutory criteria for successful electronic prescriber as reporting the measure in 50 percent of applicable cases.

There is also a limitation of the applicability of the e-prescribing incentive. For CY 2009, in order to be considered an eligible professional for purposes of the e-prescribing incentive, the e-prescribing measure denominator codes must apply to at least 10 percent of the total of allowed charges for all such covered services furnished by the eligible professional.

Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth

Currently, telehealth may substitute for a face-to-face, "hands on" encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that CMS has determined to be appropriate for telehealth. Medicare will make a fixed payment to the originating site as well as a PFS payment to the physician. The originating site must be located in a non-metropolitan statistical area (non-MSA) county or rural HPSA. To date, originating sites have been limited to: the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic (RHC); and a federally qualified health center (FQHC).

The MIPPA recognizes the following additional originating sites, effective for services furnished on or after January 1, 2009: a hospital-based or CAH-based renal dialysis center (including satellites); a skilled nursing facility (SNF); and a community mental health center (CMHC).

Additional information

The official instruction, CR 6349, issued to your Medicare A/B MAC, carrier or FI regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R4190TN.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6349

Related Change Request (CR) Number: 6349

Related CR Release Date: December 19, 2008

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Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 419, CR 6349

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LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by LCMS, 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.medicare.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 educational Web site <http://www.medicare.fcso.com>, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

More information

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

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

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APPHROG: Psychiatric partial hospitalization program	36

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.medicare.fcso.com>.

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ADDITIONS/REVISIONS TO EXISTING LCDs

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 on January 1, 2009. Since that time the LCD has been revised. Change request 6291, dated December 9, 2008, states that thermal intradiscal procedures (TIPs) are nationally noncovered. This instruction is outlined in the national coverage determination (NCD) 150.11. With the issuance of this NCD, *CPT* codes 0062T, 0063T have been removed from the “Local Noncoverage Decisions” section of the LCD and moved to the “National Noncoverage Decisions” section of the LCD. In addition, *CPT* codes 22526 and 22527 have been added to the “National Noncoverage Decisions” section of the LCD.

Effective date

This revision is effective for claims processed **on or after January 5, 2009**, for services provided **on or after September 29, 2008**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database ([List of LCDs for FCSO Inc. \(00090, Intermediary\)](#)). ❖

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APPHROG: Psychiatric partial hospitalization program – revision to the LCD

LCD ID Number: L1212

The local coverage determination (LCD) for psychiatric partial hospitalization program was last revised effective January 1, 2009. Since that time, the LCD has been revised.

Change request (CR) 6320 and CR 6315, updated the list of partial hospitalization program (PHP) billable codes. Therefore, the LCD was revised to add *CPT* codes 90817, 90819, 90822, 90824, 90827 and 90829; and to delete *CPT* codes 90853, 90857, and 90899 to/from the “*CPT*/HCPCS Codes” section of the LCD. Additionally, revenue code 910 was added to the “Revenue Code” section and verbiage was revised in the “Benefit Category” and “Reasonable and Necessary Services” sections of the LCD.

Effective date

This revision is effective for claims provided **on or after January 1, 2009**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database ([List of LCDs for FCSO Inc. \(00090, Intermediary\)](#)). ❖

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HOSPITAL SERVICES

Annual clotting factor furnishing fee update

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

Provider types affected

Providers billing Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MAC), or regional home health intermediaries (RHHI) for services related to the administration of blood clotting factors to Medicare beneficiaries.

What you need to know

Change request (CR 6277), from which this article is taken, announces that for calendar year 2009, the blood clotting furnishing factor of \$0.164 per international unit (I.U.) is added to the payment limit for a blood clotting factor that is not included on the average sales price (ASP) or not otherwise classified (NOC) files.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Section 303(e)(1) added section 1842(o)(5)(C) to the Social Security Act (the Act) which requires that, beginning January 1, 2005, a furnishing fee be paid for items and services associated with the administration of blood clotting factors. It further specifies that for calendar year (CY) 2006 (and subsequent years) this furnishing fee will be equal to the fee for the previous year, increased by the percentage increase in the consumer-price index (CPI) for medical care for the 12-month period ending with June of the previous year.

Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published payment limits for blood clotting factor billing codes included on the Medicare Part B drug ASP pricing file or NOC pricing file. Your Medicare contractor will make separate payment for the blood clotting factor furnishing fee when a separate payment for the blood clotting factor is allowed, and the payment limit for the blood clotting factor is not included on the Medicare Part B drug ASP or NOC

pricing files. The blood clotting furnishing factors for years 2005-2009 are displayed in the following table:

Blood clotting factor furnishing fee*	
Furnishing fee	Calendar year
\$0.164 per I.U.	2009
\$0.158 per I.U.	2008
\$0.152 per I.U.	2007
\$0.146 per I.U.	2006
\$0.140 per I.U.	2005

*When the blood clotting factor is not included on the Medicare Part B drug ASP or NOC pricing files

Additional information

You may find more information about the blood clotting furnishing factor by going to CR 6277, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1653CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6277

Related Change Request (CR) Number: 6277

Related CR Release Date: December 19, 2008

Related CR Transmittal Number: R1653CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1653, CR 6277

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Clarification to the adjustment for Medicare mental health services

Change request (CR) 6208 is a clarification of the mental health codes that received a 0.5 percent increase in the fee schedule payment rates for claims with dates of service on or after July 1, 2008, through December 31, 2008, under joint signature memorandum (JSM) 08410.

The increased fee schedule for these mental health codes was implemented on July 17, 2008. Contractors were instructed at that time to automatically reprocess any claims that processed under the old payment rates, for dates of service on/after July 1, 2008, with the new payment rates. FCSO has already adjusted all impacted claims with these mental health codes for dates of service on or after July 1, 2008. ❖

Source: CMS Pub. 100-20, Transmittal 426, CR 6208

Adjustment for Medicare mental health services

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

Provider types affected

Physicians, clinical psychologists (CPs), clinical social workers (CSWs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and physician assistants (PAs) who submit claims to Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), or carriers, for mental health services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6208 that identifies the CPT psychiatry procedure codes that represent mental health services that have already been increased in payment by five percent effective for these “specified services” provided on or after July 1, 2008, through December 31, 2009. Be sure your billing staff is aware of this list of CPT codes that represent “specified services”.

Key points of CR 6208

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 defines “specified services” as CPT procedure codes consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings under the subcategories of services that are insight oriented, behavior modifying, or supportive psychotherapy or, interactive psychotherapy. This list of CPT codes for specified services provides contractors with a way to link the already increased payment amounts for specified services to a particular CPT code. Accordingly, the specific psychiatry CPT codes affected by the 5 percent increase are as follows:

Insight oriented, behavior modifying and/or supportive psychotherapy – CPT codes 90804, 90805, 90806, 90807, 90808, and 90809

Interactive psychotherapy – CPT codes 90810, 90811, 90812, 90813, 90814, and 90815

Inpatient hospital, partial hospital or residential care facility (insight oriented, behavior modifying and/or supportive psychotherapy) – CPT codes 90816, 90817, 90818, 90819, 90821, 90822

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Interactive psychotherapy – CPT codes 90823, 90824, 90826, 90827, 90828, and 90829

Background

Medicare contractors were previously sent the payment rates that include the five percent increase for certain mental health services under the RV3D file for the 2008 Medicare physician fee schedule. Accordingly, Medicare contractors should have loaded the already increased payment rates that are effective from July 1, 2008, through December 31, 2009. While contractors do not have to increase payment for these codes, they will now be able to link a CPT code with the appropriate payment amount for the code. The notification under CR 6208 provides contractors with the list of CPT codes that represent the specified services under the MIPPA provision that corresponds with the increased payment amounts already in place.

Additional information

To see the official instruction (CR 6208) issued to your Medicare carrier, FI or A/B MAC visit the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R426OTN.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6208
Related Change Request (CR) Number: 6208
Related CR Release Date: December 31, 2008
Related CR Transmittal Number: R426OTN
Effective Date: July 1, 2008
Implementation Date: February 2, 2009

Source: CMS Pub. 100-20, Transmittal 426, CR 6208

Medical review initiatives for inpatient and long-term care hospital

The Centers for Medicare & Medicaid Services (CMS) wishes to inform the hospital community of the following three separate and distinct medical review activities:

1. In August 2008, the fiscal intermediaries (FIs) and Part A/Part B Medicare administrative contractors (A/B MACs) started to perform medical review on acute inpatient prospective payment system (IPPS) and long term care hospital (LTCH) claims. Please see the details in MLN Matters article MM5849 by going to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5849.pdf>.

Contractors for FIs and A/B MACs are shown by state/jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/Downloads/CurrentMaps.pdf> and <http://www.cms.hhs.gov/MedicareContractingReform/downloads/ABMACJurisdictionsMAP.pdf>.

Medical review initiatives for inpatient and long-term care hospital (continued)

These contractors have begun to request medical records as part of the medical review process. If you would like to learn more about that process, you can go to CMS Internet only manuals found at <http://www.cms.hhs.gov/home/regsguidance.asp>. The guidance may be found in the *Program Integrity Manual* (100-8) in Chapters 1, 2, 3, and 6. For questions specific to your claims review, contact your FI or A/B MAC.

2. In addition to the reviews described above, in a separate initiative required by law, CMS has contracted with Wisconsin Physician Services (WPS) to perform a limited number of medical reviews across the country of LTCH claims.
3. CMS wishes to take this opportunity to inform the hospital community of its desire to continue hospital comparative utilization reports commonly known as PEPPER Reports. CMS will provide further details in the future, when the procurement process is complete. ❖

Source: CMS PERL 200901-01

Moratorium on classification of long-term care hospitals or satellite facilities

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

What providers need to know

- On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) established a three-year moratorium on the designation of new LTCHs or satellites, and on an increase of beds in an existing LTCH.
- Be aware that statute creates certain limited exceptions to the moratorium. The Centers for Medicare & Medicaid Services (CMS) adopted an interim final rule with comments on May 22, 2008 to implement the LTCH moratorium provisions of the MMSEA.
- The CMS regional offices (RO) **will determine whether a facility qualifies for an exception to the moratorium.**
- A CMS memorandum on this subject (Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds) provides a detailed summary of the moratorium and its exceptions. This memorandum may be reviewed on the CMS Web site at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-26.pdf>.

Key Points

- If you have a project under development that may qualify for an exception, your FI/MAC will review and evaluate the documentation concerning binding agreements/actual expenditures for those projects.
- Your FI/MAC will recommend to the CMS RO whether or not a provider qualifies for an exception, based either on having begun its qualifying period prior to December 29, 2007, or on having requisite binding agreements and evidence of expenditures prior to that date.

- When/if the provider eventually submits its complete application to CMS, the FI/MAC must include the advance determination letter. It will not be necessary for the FI/MAC to conduct a new review of its eligibility for an exception to the moratorium.

Background

This article is based on change request (CR) 6172, which discusses Section 114 of the MMSEA (Pub. L. 110-173), enacted December 29, 2007, and establishes a number of provisions affecting LTCHs.

Section 114(d)(1) establishes a three-year moratorium on the designation of new LTCHs or LTCH satellites, and on an increase of beds in a LTCH. The moratorium began on December 29, 2007, and ends on December 28, 2010.

For hospitals that are seeking to be excluded from the inpatient prospective payment system for the first time as a LTCH, under the existing regulations at section 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Social Security Act, such hospitals must:

- Have a provider agreement with Medicare
- Have an average Medicare inpatient length of stay (LOS) greater than 25 days. The FI or MAC, as applicable, will verify whether the hospital meets the average LOS requirement.

Sections 114(d)(2) and (d)(3) of MMSEA provide for exceptions to the moratorium imposed by section 114(d)(1) of MMSEA. It is important to note that the two categories of exceptions, (1) establishment and classification of a LTCH or LTCH satellite and (2) increase in the number of LTCH Beds, are mutually exclusive.

The three exceptions specified in section 114(d)(2) of MMSEA are only applicable to the establishment and classification of a LTCH or LTCH satellite facility; they do not apply to the moratorium on an increase in beds at section 114(d)(1)(B) of MMSEA.

Similarly, the exception at section 114(d)(3)(A) of MMSEA only applies to the moratorium on increases in beds at existing LTCHs or LTCH satellites facilities, and not to the moratorium on the establishment of LTCHs and LTCH satellite facilities.

*Moratorium on classification of long-term care hospitals or satellite facilities (continued)***Discussion of exceptions****1. Establishment and classification of a LTCH or LTCH satellite**

The moratorium on the establishment and classification of a LTCH or LTCH satellite facility does not apply to a LTCH that, as of December 29, 2007, met one of the following three exceptions:

- The LTCH began “its qualifying period for payment as an LTCH under Section 412.23(e) of title 42, *Code of Federal Regulations*, on or before the date of enactment of this Act Section 114(d)(2)(A).” This exception applies to an existing hospital that began its qualifying period for LTCH status on or before December 29, 2007. To qualify for this exception to the moratorium, the LOS data used to demonstrate that the hospital has met the average LOS requirement at 42 CFR 412.23 must be from its cost reporting period that began on or before December 29, 2007. Note that a LTCH satellite may not qualify for this exception, since there is no “qualifying period” for the establishment of a satellite facility for payment as a LTCH under 42 CFR 412.23(e).
- As of December 29, 2007, the LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a LTCH and has expended, prior to December 29, 2007, at least 10 percent of the estimated cost of the project or, if less, \$2,500,000 (Section 114(d)(2)(B)). This exception applies in the following three circumstances:
 1. As of December 29, 2007, an existing hospital (that is, one that was certified as a hospital as of December 29, 2007) that will become a LTCH has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition for converting the hospital to a LTCH and has expended, before that date, at least 10 percent of the estimated cost of the project or \$2,500,000, whichever amount is less.
 2. As of December 29, 2007, an entity that will develop a hospital that will ultimately become a LTCH has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition of a hospital and that entity has expended, before that date, at least 10 percent of the estimated cost of the project or \$2,500,000, whichever amount is less; or
 3. An existing LTCH, as of December 29, 2007, has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease or demolition of a new LTCH satellite facility and the LTCH has expended before December 29, 2007, at least 10 percent of the estimated cost of the project or \$2,500,000, whichever amount is less.

- The LTCH has obtained an approved certificate of need (CON) in a state where one is required on or before December 29, 2007, (Section 114(d)(2)(C)). This exception applies to a hospital or entity that was actively engaged in developing a LTCH, as evidenced by the fact that either:
 1. An entity that wanted to create a LTCH, but did not exist as a hospital as of December 29, 2007, had obtained an approved CON for a hospital or LTCH, as applicable, on or before December 29, 2007. Depending on the State’s CON law, there may or may not be a CON that is specifically for a long-term acute care hospital, as opposed to one for a general or short-term acute care hospital. If there is a CON that is specifically for a LTCH in the entity’s state, then the entity must have been obtained an approved CON that is specifically for creation of a LTCH. If the state does not require a specific LTCH CON, then it is sufficient for the entity to have obtained an approved hospital CON on or before December 29, 2007, as long as it did not exist as a hospital by that date; or
 2. A hospital that did exist as a hospital on December 29, 2007, had obtained an approved CON on or before December 29, 2007, to convert the hospital into a new LTCH, or an existing LTCH had obtained an approved CON by that date to create a satellite. This exception does not apply to an existing hospital that obtained an approved CON for a hospital type other than a LTCH on or before December 29, 2007. The fact that a hospital may have had a CON issued to it years before December 29, 2007, to operate a hospital would not be a reason to grant it an exception, unless that CON was specifically for a LTCH. In a state that does not require a specific CON for a LTCH type of hospital this exception is not available to any existing hospital.

2. Increase in the number of LTCH beds

In accordance with Section 114(d)(1)(B), an existing LTCH or LTCH satellite facility may not increase the number of beds in excess of the number of Medicare-certified beds at the hospital as of December 29, 2007. Section 114(d)(3) states that the moratorium on an increase in beds shall not apply if an existing LTCH or LTCH satellite facility is “located in a state where there is only one other long-term care hospital; and requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the state.” There is further statutory language about the intersection of this exception with “grandfathered” LTCH within hospitals as specified at 42 CFR 412.22(f) and LTCH satellite facilities as specified at 42 CFR 412.22(h)(3).

Note: LTCH satellites are not considered separate LTCHs.

*Moratorium on classification of long-term care hospitals or satellite facilities (continued)***Additional information**

You may see the official instruction (CR 6172) issued to your Medicare FI, or A/B MAC, by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R418OTN.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6172

Related Change Request (CR) Number: 6172

Related CR Release Date: December 19, 2008

Related CR Transmittal Number: R418OTN

Effective Date: December 29, 2007

Implementation Date: January 20, 2009

Source: CMS Pub. 100-20, Transmittal 418, CR 6172

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Long-term care hospital special project

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

Provider types affected

Long-term care hospitals (LTCH) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in LTCHs.

Provider action needed

This article is informational in nature and requires no provider action at this time. The article is based on change request (CR) 6324 to alert providers that the Centers for Medicare & Medicaid Services (CMS) has outlined the requirements for an expanded review of LTCH admissions as required by recent legislation. CMS has selected a sampling contractor (AdvanceMed) to create the study universe of claims for this review. In addition, CMS has selected Wisconsin Physicians Service (WPS) to conduct the review. CR 6324 establishes communication procedures between the sampling contractor (AdvanceMed), LTCH review contractor (WPS), FIs, and A/B MACs to avoid duplication of effort in these review processes.

Background

In 2007, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act (MMSEA), was enacted. The Act included a provision, (Section 114) that expanded review of medical necessity of admissions to long-term care hospitals and continued stays at such hospitals. The Act also requires error rate calculation, and disallowance of days of medically unnecessary care from the calculation of the LTCH average length of stay (ALOS) as a result of those

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reviews. For purposes of carrying out the above provision of the MMSEA, CMS must ensure that an appropriate framework for cooperation exists to facilitate the exchange of information and the establishment of communication procedures among the LTCH sampling contractor (AdvanceMed), LTCH review contractor (WPS), the FIs, and A/B/MACs. CR 6324 establishes this framework.

Additional information

The official instruction (CR 6324) issued to your Medicare A/B MAC and/or FI is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R430OTN.pdf>.

If you have questions or wish to obtain information regarding the results of a review, please contact your Medicare A/B MAC or FI at their toll-free number, which may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6324

Related Change Request (CR) Number: 6324

Related CR Release Date: January 16, 2009

Related CR Transmittal Number: R430OTN

Effective Date: September 30, 2008

Implementation Date: February 17, 2009

Source: CMS Pub. 100-20, Transmittal 430, CR 6324

Medicare solicits nominees for the advisory panel on APC groups

Members to advise CMS on the clinical integrity of the ambulatory payment classification (APC) groups and their payment weights

The Centers for Medicare & Medicaid Services (CMS) is soliciting nominations for individuals to serve on the advisory panel on APC groups (the Panel) that advises the Secretary, Department of Health & Human Services as well as the administrator, CMS, about the clinical integrity of the APC groups and their associated weights, which are major elements of the Medicare hospital outpatient prospective payment system (OPPS).

Nominations are due to CMS no later than Friday, March 13, 2009, by 5 p.m. ET.

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. Since its initial chartering, the Secretary has renewed the APC Panel's Charter four times: on November 1, 2002; on November 1, 2004; effective November 21, 2006; and on November 2, 2008.

The APC Panel may be composed of up to 15 members and a Chair. The following requirements apply to all members of the Panel:

- Must be representatives of providers subject to payment under the hospital OPPS: hospitals, hospital systems, or other Medicare providers
- Cannot be consultants or independent contractors
- May be self-nominations or nominations submitted by Medicare providers and other interested organizations
- Must have technical expertise to enable them to participate fully in the Panel's work – such expertise encompasses the following:
 - ♦ hospital payment systems
 - ♦ hospital medical care delivery systems
 - ♦ provider billing systems
 - ♦ APC groups, *Current Procedural Terminology* codes, and alpha-numeric Health Care Common Procedure Coding System codes
 - ♦ use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise
- Must have a minimum of five years experience in their area(s) of expertise
- Must serve on a voluntary basis, without compensation, pursuant to advance written agreement
- Shall be entitled to receive reimbursement for travel expenses and per diem in lieu of subsistence, in accordance with standard government travel regulations

The Panel is technical in nature, and it shall deal with the following issues:

- Addressing whether procedures within an APC group are similar both clinically and in terms of resource use.
- Evaluating APC group weights.
- Reviewing the packaging of OPPS services and costs, including the methodology and the impact on APC groups and payment.
- Removing procedures from the inpatient list for payment under the OPPS.
- Using single and multiple procedure claims data for CMS' determination of APC group weights.
- Addressing other technical issues concerning APC group structure.

The current APC Panel membership and other information pertaining to the APC Panel, including its Charter, Federal Register notices, membership, meeting dates, agenda topics, and meeting reports may be viewed on the CMS Web site at http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.

Persons wishing to nominate individuals to serve on the Panel may contact Shirl Ackerman-Ross, the Designated Federal Official (DFO), at the following e-mail addresses: shirl.ackermanross@cms.hhs.gov or CMSAPCPanel@cms.hhs.gov.

Note: There is no underscore in the APC Panel e-mail address; there is a space between CMS and APCPanel.) Ms. Ackerman-Ross may also be reached at 410-786-4474.

Please mail or hand-deliver nominations to the following address:

Centers for Medicare & Medicaid Services
Attn: Shirl Ackerman-Ross, DFO
Advisory Panel on APC Groups
Center for Medicare Management
Hospital & Ambulatory Policy Group
Division of Outpatient Care
7500 Security Boulevard, Mail Stop C4-05-17
Baltimore, MD 21244-1850

Source: CMS PERL 200901-31 and PERL 200901-44

ESRD SERVICES

Clarification for billing laboratory end-stage renal disease

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

Provider types affected

Providers and laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for end-stage renal dialysis (ESRD) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6245 which clarifies existing policies related to laboratory billing procedures for laboratory services furnished to hospital-based and independent dialysis facility patients. Be sure billing staff is aware of these clarifications.

Key points

CR 6245 clarifies existing policy located in the *Medicare Claims Processing Manual*, Chapters 8 and 16 regarding billing for ESRD related laboratory services. The clarified policy chapters are attached to CR 6245 on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1655CP.pdf>.

The revisions are summarized as follows:

- Hospital-based laboratories providing separately billable laboratory services to dialysis patients of the hospital's dialysis facility or another dialysis facility bill and are paid in accordance with the hospital outpatient laboratory provisions in Chapter 16, section 40.3. This may be reviewed on the CMS Web site at <http://www.cms.hhs.gov/manuals/Downloads/clm104c16.pdf>.
- If the ESRD patient also receives other hospital outpatient services on the same day as a specimen collection and/or laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. When the patient does not also receive hospital outpatient services on the same day as the specimen collection and/or laboratory test, then the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.
- Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with the Clinical Laboratory Improvement Act (CLIA) may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests

according to the Medicare laboratory fee schedule for independent laboratories. (See Chapter 16, Section 40.3 [as referenced above] for details on Part B hospital billing rules for laboratory services.)

- When a hospital laboratory is billing for laboratory services ordered by an ESRD facility and the patient (beneficiary) is a skilled nursing facility (SNF) resident under a Part A stay, the hospital laboratory must use the modifier CB for those services excluded from consolidated billing.
- Beneficiaries in a skilled nursing facility (SNF) Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic tests that are not directly related to the beneficiary's ESRD are subject to the SNF consolidated billing requirements. Physicians may bill the contractor for the professional component of these diagnostic tests. In most cases, however, the technical component of diagnostic tests is included in the SNF prospective payment system (PPS) rate and is not separately billable to the contractor.
- If you have claims that may not have been paid correctly based on the above clarifications, note that your Medicare contractor will not search its files to adjust the claims. However, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 6245, issued to your Medicare MAC, carrier or FI regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1655CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6245
 Related Change Request (CR) Number: 6245
 Related CR Release Date: December 31, 2008
 Related CR Transmittal Number: R1655CP
 Effective Date: January 1, 2009
 Implementation Date: February 2, 2009

Source: CMS Pub. 100-04, Transmittal 1655, CR 6245

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Announcement of the renal CROWNWeb system implementation

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the renal CROWNWeb system will move from its testing environment to a production/implementation environment on February 1, 2009. At that time, CMS will launch CROWNWeb to a small, select group of providers across the country representing both large and small dialysis organizations, as well as independent dialysis facilities across the country. CMS will expand implementation as it learns more about how the system functions within individual facilities.

Until facilities are phased in to CROWNWeb implementation, they should continue with their normal business operations and reporting requirements, including using the SIMS, VISION, and paper-based data submissions.

Facilities that are not part of the first phase of implementation may continue to meet their requirements under the end-stage renal disease (ESRD) conditions for coverage by continuing to use these submission methods.

CROWNWeb is a secure, Web-based system that will capture clinical and administrative data from dialysis facilities across the country, supplanting the paper-based data collection methods that CMS currently uses.

CROWNWeb is CMS first step in leveraging the benefits of health information technology for the dialysis population and will help to improve the quality of data Medicare receives about dialysis treatments, help providers focus on providing optimal patient care, drive innovations and quality improvement of care practices, and equip CMS with more data to develop a more refined and responsive ESRD bundled-payment system and ESRD value-based purchasing framework.

More support will be available to dialysis facilities from their local ESRD network organizations. A list of networks is online at

<http://www.medicare.gov/Dialysis/Static/ContactList.asp?dest=NAV/Home/Resources/ESRDContacts/Contacts&ContactType=ESRD>.

Facilities may also call the CROWN Help Desk at 1-888-ESRD-HD1 or email ESRDHD1@esrd.net.

Consumers who wish to learn more about dialysis facilities in their communities may visit the Dialysis Facility Compare Web site at <http://www.medicare.gov/dialysis> for information. ❖

Source: CMS PERL 200901-29

Update to the end-stage renal disease PC PRICER

The Centers for Medicare & Medicaid Services (CMS) has updated the PC PRICER Web page at http://www.cms.hhs.gov/PCPricer/02e_ESRD_Pricer.asp#TopOfPage to include the updated end-stage renal disease (ESRD) PC PRICER with the rates for 2009. The PC PRICER is located in the Downloads section of the Web page. ❖

Source: CMS PERL 200901-26

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 contractor. 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.medicare.fcso.com>, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

SKILLED NURSING FACILITY SERVICES

Five-star quality rating data for nursing home providers

The Centers for Medicare & Medicaid Services (CMS) is giving nursing home providers another preview of the five-star quality rating data as this is a relatively new program. Please visit your quality improvement evaluation system (QIES) mailbox now (available through your electronic connection to the state servers for submission of minimum data set [MDS] data) to review your results.

To access these reports, select the Certification and Survey Provider Enhanced Reporting (CASPER) link located at the bottom of the homepage. Once in the CASPER system, click on the “Folders” button and access the five-star report in your “st LTC facid” folder, where “st” is the two-digit postal code of the state in which your facility is located, and “facid” is the state assigned identifier of your facility.

Although Nursing Home Compare is generally updated on the third Thursday of the month, CMS has built in a one-week delay to allow you time to review your rating prior to the update of the Web site. CMS has also reinstated the help desk at 1-800-839-9290, which is open from 9:00 a.m. to 5:00 p.m. ET to address any concerns. ❖

Source: CMS PERL 200901-24

Skilled nursing facility consolidated billing as it relates to ambulance services

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) revised this article to add the note under “Roundtrip to a physician’s office” regarding transportation between a skilled nursing facility (SNF) and a physician’s office. All other information remains the same. The special edition *MLN Matters* article SE0433 was published in the November 2007 *Medicare A Bulletin* (pages 26-27).

Provider types affected

Skilled nursing facilities (SNFs), physicians, ambulance suppliers, and providers

Provider action needed

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor [DME MAC]).

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the

services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf>.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

Skilled nursing facility consolidated billing as it relates to ambulance services (continued)

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH). (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.)
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care.
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below).
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance trips to receive excluded outpatient hospital services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, the outside supplier should bill separately under Part B an ambulance trip from the SNF to the hospital for the receipt of such services. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other ambulance trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers between two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under section 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a physician's office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Note: Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting. However, the regulations at 42 CFR 409.27(c), which describe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate by reference only the Part B ambulance benefit's general medical necessity requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated), and not any of the more

Skilled nursing facility consolidated billing as it relates to ambulance services (continued)

detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). Thus, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance, that ambulance roundtrip would be the responsibility of the SNF.

Noncoverage of transportation by any means other than ambulance

In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van. Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary--that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance--for example, via wheelchair van--the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance also would not be covered (because the use of an ambulance in such a situation would not be medically necessary). As with any noncovered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to "... inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."

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Additional information

See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf>.

The Centers for Medicare & Medicaid Services (CMS) MLN Consolidated Billing is on the CMS Web site at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing Web site may be found on the CMS Web site at http://www.cms.hhs.gov/SNFPSPS05_ConsolidatedBilling.asp.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

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CORF/ORF SERVICES

Holding therapy claims with Current Procedural Terminology code 95992

Change request (CR) 6254 updated the Medicare therapy code list for calendar year 2009 with *Current Procedural Terminology (CPT) code 95992 – Canalith repositioning procedure(s) (e.g. Epley maneuver, Semont maneuver), per day.*

The Center for Medicare & Medicaid Services (CMS) has notified contractors that CR 6254 inadvertently omitted the bundled status indicator for CPT code 95992. As a result, claims containing CPT code 95992 are suspending in the system with reason code WW423 to location status S/MSPRT until the fiscal intermediary shared system performs the necessary programming changes to process the therapy claims correctly.

Implementation for this system change is expected to occur on March 2, 2009; however, additional reimbursement for CPT code 95992 will not be made since this is considered a bundled code under the Medicare physician fee schedule.

Action required by provider

Providers may remove CPT code 95992 prior to submission of the therapy claims. Once the system changes have been implemented, providers may perform an adjustment to the therapy claim to include the bundle CPT code 95992. This action will mitigate any financial impact for other services provided on the claim. ❖

Source: CMS JSM 09132, January 22, 2009

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HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2009 integrated outpatient code editor specifications

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

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) that are subject to the edits of the integrated code editor (I/OCE).

Provider action needed

This article is based on change request (CR) 6315, which describes changes to the January 2009 update of the I/OCE. CR 6315 provides the I/OCE instructions and specifications that will be used under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, and for all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness. Be sure billing staffs are aware of these changes.

Background

CR 6315 describes changes to billing instructions for various payment policies implemented the January 2009 update of the I/OCE. Attached to CR 6315 are lengthy specifications for the I/OCE. The full CR 6315 may be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R1664CP.pdf>, but a summary of the changes for January 2009 is within Appendix M of Attachment A of CR 6315 and that summary is captured in the following key points.

Key points of CR 6315 based on Appendix M of the I/OCE specifications

Part 1 of Appendix M

- Item 1 of Appendix M has no impact on providers. This is an I/OCE logic change that supports the policy covered in #6 below.
- For CY 2009, Medicare replaced current status indicator “Q” with three new separate status indicators: “Q1,” “Q2,” and “Q3.” Status indicator “Q1” is assigned to all “STVX-packaged codes;” status indicator “Q2” is assigned to all “T-packaged codes;” and status indicator “Q3” is assigned to all codes that may be paid through a composite ambulatory payment classification (APC) based on composite-specific criteria or separately through single code APCs when the criteria are not met. The change to establish new status indicators “Q1,” “Q2,” and “Q3 facilitates the use of status indicator-driven logic in Medicare rate setting calculations, and in hospital billing and accounting systems. For calendar year (CY) 2009, Medicare is using new payment status indicator “R” for all blood

and blood product APCs. This new status indicator was created in order to facilitate implementation of the reduced market basket conversion factor that applies to payments to hospitals that are required to report quality data but fail to meet the established quality reporting standards. This reduced conversion factor applies to CY 2009 payment for blood and blood products. For CY 2009, Medicare created a new status indicator “U” to designate brachytherapy source APCs for which separate payment is made in CY 2009.

- For CY 2009, Medicare is implementing a new edit for mental health HCPCS codes that are not payable outside the partial hospital program submitted on hospital outpatient type of bill (TOBs) without condition code 41. Claims that meet these criteria will be returned to the provider.
- For CY 2009, Medicare is implementing a new OPPS edit for claims when code C9898 is billed with charges greater than \$1.01. Claims that meet these criteria will be returned to the provider.
- For CY 2009, Medicare is implementing a new edit that results in a line item denial for services provided on or after the effective date of NCD noncoverage.
- For CY2009, Medicare will pay for multiple imaging procedures performed during a single session using the same imaging modality by applying a composite APC payment methodology. The services will be paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The composite APC payment methodology for multiple imaging services utilizes three imaging families (ultrasound, CT and CTA, and MRI and MRA) and results in the creation of five new composite APCs:
 APC 8004 (ultrasound composite)
 APC 8005 (CT and CTA without contrast composite)
 APC 8006 (CT and CTA with contrast composite)
 APC 8007 (MRI and MRA without contrast composite)
 APC 8008 (MRI and MRA with contrast composite).
 When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the “with contrast” composite APC (either APC 8006 or 8008) will be assigned.
- For CY 2009, Medicare is creating two new APCs, 0172 (Level I partial hospitalization (3 services))

January 2009 integrated outpatient code editor specifications (continued)

- and 0173 (Level II partial hospitalization (4 or more services)), to replace APC 0033 (partial hospitalization), which is being deleted for CY 2009. When a community mental health center (CMHC) or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital will be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital will be paid through APC 0173.
8. For CY 2009, Medicare will reduce payment only for procedure codes that map to the APCs on the list of APCs subject to the adjustment for devices furnished without cost or with a full or partial credit from the manufacturer that are reported with modifier –FB or –FC, and that are present on claims with specified device HCPCS codes.
 9. For CY 2009, Medicare will include HCPCS code G0384 (Level 5 hospital type B ED visit) in the criteria that determine eligibility for payment of composite APC 8003 (Level II extended assessment and management). APC 8003 (Level II extended assessment and management composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (status indicator T) or the hours of observation care reported are less than 8.
 10. For CY 2009, Medicare has updated the list of codes approved for the partial hospitalization program.
 11. No impact on providers.
 12. With the APC split for PHP, the payment rate for the Daily Mental Health cap (APC 34) will be set to equal the payment rate for the Level II PHP APC (APC 173).
 13. To solve the issue of processing differences between date of discharge (inpatient) and “from” date of service (outpatient), TOB 12x was added to the bypass for diagnosis edits (1-5) if claim From date is <10/1/xx and Through date is >= 10/1/xx.
 14. National correct coding initiative (NCCI) edits are updated quarterly and the institutional version is one calendar quarter behind the physician version. **In the past, the OCE had not applied the NCCI edits for the following categories of services: anesthesiology, evaluation and management, and mental health services.** For CY 2009, Medicare has determined that these categorical exclusions will no longer apply. As a result, a large number of new institutional NCCI edits will be applied to claims effective January 1, 2009 to take into account the edits that were previously excluded. Providers are encouraged to begin to educate their staff about the application of the additional categories of NCCI edits to their claims.
 15. For CY 2009, Medicare has determined that deductible is not applicable to HCPCS codes G0402 and Q0091.
 16. No impact on providers.
 17. For CY 2009, Medicare has determined that *current procedural terminology (CPT) code 0183T, Low frequency, non-contact, non-thermal ultrasound, including topical application(s)*, when performed, wound assessment, and instruction(s) for ongoing care, per day, is newly designated as a “sometimes therapy” wound care service. In CY 2009, hospitals will receive separate payment under the OPSS when they bill for wound care services described by CPT code 0183T that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, “GP” for physical therapy, “GO” for occupational therapy, and “GN” for speech language pathology) or report their charges under a therapy revenue code (that is, revenue codes in the 042x, 043x, or 044x series), or both, to receive payment under the Medicare physician fee schedule (MPFS).
 18. No impact on providers.
 19. For OPSS CY 2009, Medicare will package code G0177 into the mental health composite (APC 34), if present, but it will not contribute to the mental health cap.
- Part 2 of Appendix M**
1. HCPCS/APC/SI (status indicator) changes were made to various codes per legislation and review as specified by the Centers for Medicare & Medicaid Services (CMS).
 2. See 14 above.
 3. In July 2007, the CPT Editorial Panel released two vaccine codes on the American Medical Association Web site, specifically CPT codes 90681 and 90696 that were implemented in January 2008. Although the vaccines associated with these codes were not approved by the Food and Drug Administration (FDA) until April 3, 2008, (for CPT code 90681) and June 24, 2008 (for CPT code 90696), and Medicare did not assign the codes to separate APCs under the OPSS until the January 2009 update, their payments are retroactive to the FDA approval dates.. Items that are reported using these HCPCS codes with dates of service prior to the date of the FDA approval will be rejected.
 4. See preceding item.
 5. Medicare will implement a mid-quarter noncoverage date for codes 0062T, 0063T, 22526, and 22527.
 6. Medicare has removed code J1051 from the list of procedures for “Females Only.”
- 1-21. These items are documentation changes for the I/OCE and are N/A.

January 2009 integrated outpatient code editor specifications (continued)

Additional Information

The official instruction (CR 6315) issued to your Medicare MAC, RHHI, or FI is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1664CP.pdf>.

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

The toll-free number for the 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: 6315

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January 2009 update of the hospital outpatient prospective payment system

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6320, which describes changes to the OPPS to be implemented in the January 2009 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 6320 describes changes to and billing instructions for various payment policies implemented in the January 2009 OPPS update. The January 2009 integrated outpatient code editor (I/OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this notification.

January 2009 revisions to I/OCE data files, instructions, and specifications are provided in CR 6315, “January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0.” Upon release of CR 6315, a related *MLN Matters* article will be available on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6315.pdf>.

Key OPPS updates for January 2009

1. New status indicators for the calendar year (CY) 2009

For CY 2009, CMS is replacing current status indicator “Q” with three new separate status indicators: “Q1,” “Q2,” and “Q3.” status indicator “Q1” is assigned to all “STVX-packaged codes;” status indicator “Q2” is assigned to all “T-packaged codes;” and status indicator “Q3” is assigned to all codes that may be paid

through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met. The change to establish new status indicators “Q1,” “Q2,” and “Q3” helps to make Medicare policies more transparent to hospitals and facilitates the use of status indicator-driven logic in CMS rate-setting calculations, and in hospital billing and accounting systems.

For CY 2009, CMS is using new payment status indicator “R” for all blood and blood product APCs. This new status indicator was created in order to facilitate implementation of the reduced market basket conversion factor that applies to payments to hospitals that are required to report quality data but fail to meet the established quality reporting standards. This reduced conversion factor applies to CY 2009 payment for blood and blood products.

Also, CMS created new status indicator “U” to designate brachytherapy source APCs for which separate payment is made in CY 2009. This definition does not specify the payment methodology. CY 2009 payment for brachytherapy sources, to which the reduced market basket conversion factor does not apply, is discussed in detail in section 20 below.

2. Reporting unlisted services or procedures

An unlisted HCPCS code represents an item, service, or procedure for which there is no specific *Current Procedural Terminology (CPT)* or Level II alphanumeric HCPCS code. The CPT code book lists a number of unlisted service or procedure codes, which may be found at the end of a section or subsection. The long descriptors for these codes start with the term “Unlisted” and the last two digits of the codes often end in “99.”

Under the OPPS, CMS generally assigns the unlisted service or procedure codes to the lowest level APC within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged.

January 2009 update of the hospital outpatient prospective payment system (continued)

For non-OPPS payment purposes, when an unlisted service or procedure code is reported, a report describing the service or procedure should be submitted with the claim. Pertinent information includes a definition or description of the nature, extent, and need for the procedure or service, as well as the provider's time, effort, and equipment necessary to provide the service.

When a Medicare contractor receives a claim with an unlisted HCPCS code for non-OPPS payment, the contractor shall verify that no existing HCPCS code adequately describes the procedure or service. Unlisted codes should be reported only if no other specific HCPCS codes adequately describe the procedure or service. If an unlisted code is submitted on a claim and the contractor has verified that the code submitted is correct, the contractor pays the claim using the unlisted code, based on the applicable non-OPPS payment methodology. However, if it is determined that an unlisted code was submitted in error because the procedure or service is described by a specific HCPCS code, the contractor shall advise the hospital (or critical access hospital [CAH]) of the appropriate code and process the claim with the correct code. If a procedure or service reported with an unlisted code is reported frequently, the contractor shall advise the provider that a request for a specific CPT code or alphanumeric HCPCS code should be made.

The latest list of "unlisted" CPT codes for procedures and services may be found under the category titled "Annual Policy Files" at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>.

3. National Correct Coding Initiative (NCCI) edits update

The NCCI edits are updated quarterly and the institutional version is one calendar quarter behind the physician version. In the past, the outpatient code editor (OCE) had not applied the NCCI edits for the following categories of services: anesthesiology, evaluation and management, and mental health services. Effective January 1, 2009, these categorical exclusions will no longer apply. As a result, a large number of new institutional NCCI edits will be applied to claims effective January 1, 2009 to take into account the edits that were previously excluded. The NCCI files are available on the CMS Web site at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>.

One may use anesthesiology, evaluation and management, or mental health services CPT or Level II HCPCS codes to search these files.

4. Payment adjustment for failure to meet the hospital outpatient quality reporting requirements

Effective for services furnished on or after January 1, 2009, Section 1833(t)(17)(A) of the Act requires that "Subsection (d) hospitals" that have failed to meet the specified hospital outpatient quality reporting requirements for the relevant calendar year will receive payment under the OPPS that reflects a two

percentage point reduction of the annual OPPS update factor. See <http://www.qualitynet.org/> for information on complying with the reporting requirements and standards that must be met to receive the full update. See *MLN Matters* article MM6072 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6072.pdf> for information on this issue.

Note: When Transmittal 368 (CR 6072) was issued, CMS inadvertently omitted status indicator "R" in the specifications for the services to which the reduction is applicable and did not list status indicator "R" in the Business Requirements. CMS is making a correction to include blood APCs with status indicator "R" under the application of the quality reporting ratio where appropriate.

For the CY 2009 OPPS, the reduced conversion factor that will apply to payments for applicable services to subsection (d) hospitals that have failed to meet the specified hospital outpatient quality reporting requirements for CY 2009 is \$64.784. The full CY 2009 OPPS conversion factor that will apply to payments for applicable services to Subsection (d) hospitals that have satisfied the specified hospital outpatient quality reporting requirements for CY 2008 is \$66.059. The reporting ratio by which the payment and copayment for (d) hospitals that failed to meet the specified hospital outpatient quality reporting requirements for the CY 2009 update is 0.981.

The quality reporting support contractor to whom FIs/MACs should refer new hospitals is FMQAI, which may be contacted at hoppqdrp@fmqai.com, by phone at 1-866-800-8756, or in writing at:

FQMAI
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609.

5. CY 2009 transitional outpatient payments

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008 for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009 to sole community hospitals with 100 or fewer beds.

Eighty-five percent of hold harmless TOPs shall continue for services rendered through December 31, 2009, for rural hospitals with 100 or fewer beds. Eighty-five percent of hold harmless TOPs shall be paid for services rendered through December 31, 2009, for sole community hospitals with 100 or fewer

January 2009 update of the hospital outpatient prospective payment system (continued)

beds. Essential access community hospitals (EACHs) are considered to be sole community hospitals under Section 1886(d)(5)(D)(iii)(III) of the Act. Therefore, EACHs are also eligible for TOPs payments for CY 2009. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

For purposes of TOPs, a hospital is considered rural if it is either geographically rural or classified to rural for wage index purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for wage index purposes. A hospital that is geographically urban, but reclassified to rural for the wage index, is considered rural for purposes of TOPs.

6. Outlier reconciliation

Section 1833(t)(5) of the Social Security Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for outpatient services furnished when they incur extraordinarily high costs. This additional payment, known as an "outlier," is designed to mitigate the financial risk associated with extremely costly and complex services. In order to qualify for outlier payments, services must have estimated cost above a fixed-dollar threshold and a multiple threshold, which are published in the annual OPSS final rule. The regulations governing payments for outlier cases are located at 42 CFR 419.43.

As provided in Section 1833(t)(5)(D) of the Act, CMS uses each hospital overall cost to charge ratio (CCR), rather than a CCR for each department within the hospital, to estimate costs from charges for outlier payments. To ensure that an accurate CCR is used to estimate cost, CMS already requires substitution of a statewide average CCR when the Medicare contractor is unable to identify an accurate CCR for a hospital, including hospitals that are new, hospitals experiencing a change of ownership that have not accepted assignment, and hospitals with CCRs greater than the upper limit. Under 42 CFR 419.43(d)(5)(i), CMS also may specify an alternative to the overall ancillary CCR from the hospital or community mental health center (CMHC) most recently settled or tentatively settled cost report. Further, a hospital or CMHC may request that its Medicare contractor use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Such a request must be approved by CMS. Under 42 CFR 419.43(d)(6)(i), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the service was furnished. Since OPSS outlier payments are no longer final payments, CMS will consider reprocessing claims for errors in CCRs or outlier payments on a case by case basis.

In addition, under 42 CFR 419.43(d)(6)(ii), for hospital outpatient services furnished during cost reporting

periods beginning on or after January 1, 2009, at the time of reconciliation under 42 CFR 419.43(d)(6)(i), outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

CMS is clarifying OPSS CCR and outlier reconciliation policies for Medicare contractors, specifically, when to specify an alternative CCR other than a Statewide average or one calculated from the hospital or CMHC's most recent cost report; how to use the outlier reconciliation thresholds to determine eligibility for reconciliation; how to execute OPSS outlier reconciliation; and how the time value of money will be applied to the amount of outlier under or overpayment. CMS has not finished the program that will recalculate outlier payments using the CCR determined at final settlement. Further instructions on performing outlier reconciliation will be forthcoming when this utility becomes available.

7. Partial hospitalization APC 0172 and APC 0173

For CY 2009, CMS is creating two new APCs, 0172 (Level I partial hospitalization [three services]) and 0173 (Level II partial hospitalization [four or more services]), to replace APC 0033 (partial hospitalization), which CMS is deleting for CY 2009. When a CMHC or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital would be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital would be paid through APC 0173. The *Medicare Claims Processing Manual*, Chapter 4, sections 260.1 and 260.1.1 are revised to reflect these new APCs.

8. Mental health services composite APC 0034

Since the beginning of the OPSS, CMS set the annual payment rate for the mental health composite APC at the same rate as APC 0033, the partial hospitalization APC. For CY 2009, CMS is creating two new APCs, 0172 (Level I partial hospitalization [three services]) and 0173 (Level II partial hospitalization [four or more services]), to replace APC 0033 (partial hospitalization), which we are deleting for CY 2009. When a CMHC or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital would be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital would be paid through APC 0173.

CMS set the CY 2009 payment rate for mental health composite APC 0034 at the same rate as APC 0173 (\$200.17), which is the maximum partial hospitalization per diem payment. The I/OCE will continue to determine whether to pay specified mental health services individually or to make a single payment at

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the same rate as the APC 0173 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. Through the I/OCE, when the payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment [listed as APC 0173], those specified mental health services would be assigned to APC 0034 (mental health services composite), which has the same payment rate as APC 0173, and the hospital would be paid one unit of APC 0034.

9. Payment for multiple imaging composite APCs

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality will be paid by applying a composite APC payment methodology. The services will be paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic will determine the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals receive a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session.

The composite APC payment methodology for multiple imaging services utilizes three imaging families (ultrasound, CT and CTA, and MRI and MRA) and results in the creation of five new composite APCs: APC 8004 (ultrasound composite); APC 8005 (CT and CTA without contrast composite); APC 8006 (CT and CTA with contrast composite); APC 8007 (MRI and MRA without contrast composite); and APC 8008 (MRI and MRA with contrast composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the “with contrast” composite APC (either APC 8006 or 8008) will be assigned. The specified CPT codes within the three imaging families and five composite APCs are provided as follows:

Family 1 – Ultrasound

APC 8004 Ultrasound Composite

- 76604 *Us exam, chest*
- 76700 *Us exam, abdom, complete*
- 76705 *Echo exam of abdomen*
- 76770 *Us exam abdo back wall, comp*
- 76775 *Us exam abdo back wall, lim*
- 76776 *Us exam k transpl w/doppler*
- 76831 *Echo exam, uterus*
- 76856 *Us exam, pelvic, complete*
- 76870 *Us exam, scrotum*
- 76857 *Us exam, pelvic, limited*

Family 2 – CT and CTA with and without contrast

APC 8005 CT and CTA without contrast composite*

- 0067T *Ct colonography;dx*
- 70450 *Ct head/brain w/o dye*

- 70480 *Ct orbit/ear/fossa w/o dye*
- 70486 *Ct maxillofacial w/o dye*
- 70490 *Ct soft tissue neck w/o dye*
- 71250 *Ct thorax w/o dye*
- 72125 *Ct neck spine w/o dye*
- 72128 *Ct chest spine w/o dye*
- 72131 *Ct lumbar spine w/o dye*
- 72192 *Ct pelvis w/o dye*
- 73200 *Ct upper extremity w/o dye*
- 73700 *Ct lower extremity w/o dye*
- 74150 *Ct abdomen w/o dye*

APC 8006 CT and CTA with contrast composite

- 70487 *Ct maxillofacial w/dye*
- 70460 *Ct head/brain w/dye*
- 70470 *Ct head/brain w/o & w/dye*
- 70481 *Ct orbit/ear/fossa w/dye*
- 70482 *Ct orbit/ear/fossa w/o&w/dye*
- 70488 *Ct maxillofacial w/o & w/dye*
- 70491 *Ct soft tissue neck w/dye*
- 70492 *Ct sft tsue nck w/o & w/dye*
- 70496 *Ct angiography, head*
- 70498 *Ct angiography, neck*
- 71260 *Ct thorax w/dye*
- 71270 *Ct thorax w/o & w/dye*
- 71275 *Ct angiography, chest*
- 72126 *Ct neck spine w/dye*
- 72127 *Ct neck spine w/o & w/dye*
- 72129 *Ct chest spine w/dye*
- 72130 *Ct chest spine w/o & w/dye*
- 72132 *Ct lumbar spine w/dye*
- 72133 *Ct lumbar spine w/o & w/dye*
- 72191 *Ct angiograph pelv w/o&w/dye*
- 72193 *Ct pelvis w/dye*
- 72194 *Ct pelvis w/o & w/dye*
- 73201 *Ct upper extremity w/dye*
- 73202 *Ct uppr extremity w/o&w/dye*
- 73206 *Ct angio upr extrm w/o&w/dye*
- 73701 *Ct lower extremity w/dye*
- 73702 *Ct lwr extremity w/o&w/dye*
- 73706 *Ct angio lwr extr w/o&w/dye*
- 74160 *Ct abdomen w/dye*
- 74170 *Ct abdomen w/o & w/dye*
- 74175 *Ct angio abdom w/o & w/dye*
- 75635 *Ct angio abdominal arteries*

* If a “without contrast” CT or CTA procedure is performed during the same session as a “with contrast” CT or CTA procedure, assign APC 8006 rather than 8005.

Family 3 – MRI and MRA with and without contrast

APC 8007 (MRI and MRA without contrast composite)*

- 70336 *Magnetic image, jaw joint*
- 70540 *Mri orbit/face/neck w/o dye*
- 70544 *Mr angiography head w/o dye*
- 70547 *Mr angiography neck w/o dye*
- 70551 *Mri brain w/o dye*
- 70554 *Fmri brain by tech*
- 71550 *Mri chest w/o dye*
- 72141 *Mri neck spine w/o dye*
- 72146 *Mri chest spine w/o dye*

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72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis

APC 8008 (MRI and MRA with contrast composite)

70549	Mr angiograph neck w/o&w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orb/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis

* If a “without contrast” MRI or MRA procedure is performed during the same session as a “with contrast” MRI or MRA procedure, assign APC 8008 rather than 8007.

10. Payment for extended assessment and management composite APCs

Beginning January 1, 2009, HCPCS code G0384 (Level 5 hospital type B ED visit) will be included in the criteria that determines eligibility for payment of composite APC 8003 (Level II extended assessment and management). APC 8003 (Level II extended assessment and management composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (status indicator T) or the hours of observation care reported are less than 8. The I/OCE will evaluate every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the OPPTS PRICER, will determine the appropriate status indicator, APC, and payment for every code on a claim.

11. Billing for wound care services

As provided under Section 1834(k)(5) of the Social Security Act, CMS has created a therapy code list to identify and track therapy services paid under the Medicare physician fee schedule (MPFS). CMS provides this list of therapy codes along with their respective designations in the *Medicare Claims Processing Manual*, Chapter 5, Section 20. Two of the designations that CMS uses in that manual denote whether the listed therapy code is an “always therapy” service or a “sometimes therapy” service. For CY 2009, CPT code 0183T, low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day, is newly designated as a “sometimes therapy” wound care service. In CY 2009, hospitals will receive separate payment under the OPPTS when they bill for wound care services described by CPT code 0183T that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, “GP” for physical therapy, “GO” for occupational therapy, and “GN” for speech language pathology) or report their charges under a therapy revenue code (that is, revenue codes in the 042x, 043x, or 044x series), or both, to receive payment under the MPFS.

12. Further clarification related to billing for medical and surgical supplies

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the *Medicare Claims Processing Manual*, Chapter 20, Section 10.1) described by HCPCS codes with status indicators other than “H” or “N,” are provided incident

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

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

When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment.

13. Reporting hospital critical care services under the OPSS

Hospitals should separately report all HCPCS codes in accordance with correct coding principles, *CPT* code descriptions, and any additional CMS guidance, when available. Specifically with respect to *CPT* code 99291, *Critical care, evaluation and management of the critically ill or critically injured patient*, first 30-74

minutes, hospitals must follow the *CPT* instructions related to reporting that *CPT* code. Any services that *CPT* indicates are included in the reporting of *CPT* code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the *CPT* codes specified by *CPT*) should not be billed separately by the hospital. Instead, hospitals should report charges for any services provided as part of the critical care services. In establishing payment rates for critical care services, and other services, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for critical care services, and other services, according to the standard OPSS methodology for packaging costs.

The July 2008 OPSS quarterly update, Transmittal 1536, CR 6094, issued on June 19, 2008, contains further clarification about the reporting of *CPT* codes for hospital outpatient services paid under the OPSS. For further information, readers may want to review the related *MLN Matters* article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6094.pdf>.

14. Changes to the initial preventive physical examination (IPPE)

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), extends the eligibility period for receiving an IPPE from six months to 12 months following the beneficiary's initial enrollment in Medicare Part B, effective January 1, 2009. Any beneficiary who has not yet had an IPPE and whose initial enrollment in Medicare began in CY 2008 will be able to have an IPPE in CY 2009, as long as it is done within 12 months of the beneficiary's initial enrollment. Medicare will pay for one IPPE for each beneficiary in a lifetime. The Medicare deductible does not apply to the IPPE if it is performed on or after January 1, 2009. OPSS providers will report IPPE visits occurring on or after January 1, 2009 using new HCPCS code G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). HCPCS code G0344 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment) will be active until December 31, 2008, for beneficiaries who have an IPPE prior to January 1, 2009.

The policy for reporting a medically necessary hospital visit during the same visit as the IPPE continues to apply for CY 2009. The *CPT* codes 99201 through 99215 for hospital clinic visits of new and established patients at all five levels of resource intensity may also be appropriately reported, depending on the circumstances, but they must be appended with the *CPT* modifier 25, identifying the hospital visit as a separately identifiable service from the IPPE described by HCPCS code G0402.

The MIPPA also removes the screening electrocardiogram (EKG) as a mandatory requirement to be performed as part of the IPPE. The MIPPA requires that there be education, counseling, and referral for an EKG, as appropriate, for a once-in-a-lifetime

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screening EKG performed as a result of a referral from an IPPE. The facility service for the screening EKG (tracing only) is payable under the OPPS when it is the result of a referral from an IPPE. Providers paid under the OPPS should report new HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads, tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination) for services furnished on or after January 1, 2009. HCPCS code G0367 (Tracing only, without interpretation and report, performed as a component of the initial preventive physical performed prior to January 1, 2009.

15. Changes to device edits for January 2009

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS rate setting. Both types of device edits can be found on the CMS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>. Failure to pass these edits will result in the claim being returned to the provider.

16. Manual updates for the no cost/full credit and partial credit device payment adjustment policy

CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Sections 20.6.9, 20.6.10, and 61.3 to clarify correct coding and charging practices for devices furnished without cost or with a full or partial credit from the manufacturer. Effective January 1, 2009, payment is reduced only for procedure codes that map to the APCs on the list of APCs subject to the adjustment that are reported with modifier FB or FC, and that are present on claims with specified device HCPCS codes.

17. Manual updates for billing no cost items, investigational device exemption (IDE), and qualifying clinical trials

CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Sections 67-69 to clarify correct billing practices for no cost items, IDE devices, and routine costs, and qualifying clinical trials. Typically, institutional providers should not report the usage of a no cost item. However, for some claims, providers may be required to bill a no cost item, including certain IDE devices and other items provided free of charge in a clinical trial, due to claims processing edits such as the OPPS procedure-to-device edits. Because these edits require a device to be billed along with an associated service, even if the item was received at no cost, OPPS providers must report a token charge of less than \$1.01 for the item in the covered charge field, along with HCPCS modifier FB appended to the procedure code that reports the service that requires the device.

18. Payment for implanted prosthetic devices furnished to hospital inpatients who have coverage under Part B of Medicare but do not have coverage of inpatient hospital services under Medicare Part A at the time that the device is furnished

Effective for services furnished on and after January 1, 2009 Medicare will make separate payment for implanted prosthetic devices furnished to hospital inpatients who have coverage under Part B of Medicare, but who do not have coverage of inpatient hospital services under Medicare Part A at the time the device is furnished. To receive payment for these services, hospitals must determine if the device furnished meets the definition of an implanted prosthetic device as defined in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10, which is available on the CMS Web site at <http://www.cms.hhs.gov/manuals/IOM/list.asp>.

If so, hospitals should report the implanted prosthetic device using HCPCS code C9899, long descriptor: Implanted prosthetic device, payable only for inpatients who do not have inpatient coverage, and short descriptor: Inpt implant pros dev, no cov. The Medicare contractor will determine whether payment may be made and if so, will establish the payment to be made and the amount of copayment for which the beneficiary will be liable. For more details, see *MLN Matters* article MM6050 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6050.pdf>.

19. Stereotactic radiosurgery (SRS) CPT code 61793

For CY 2009, CPT code 61793, *Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions*, was deleted on December 31, 2008, and replaced with several new CPT codes, specifically CPT codes 61796, 61797, 61798, 61799, 61800, 63620, and 63621, effective January 1, 2009. Similar to its predecessor code, all of the replacement codes have been assigned status indicator “B” under the OPPS because CMS continues

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to recognize the HCPCS G-codes for SRS treatment delivery services under the OPSS. Refer to Section 200.3 (Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SRS)) of Chapter 4 of the Medicare Claims Processing Manual for information on the G-codes. The replacement codes for CPT code 61793 are displayed in Table 1 below.

Table 1 – Replacement codes for CPT code 61793, effective January 1, 2009

CPT code	Long descriptor	CY 2009 SI
61796	<i>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion</i>	B
61797	<i>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple</i>	B
61798	<i>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 complex cranial lesion</i>	B
61799	<i>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex</i>	B
61800	<i>Application of stereotactic headframe for stereotactic radiosurgery</i>	B
63620	<i>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion</i>	B
63621	<i>Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion</i>	B

20. Payment for brachytherapy sources

The MIPPA requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at hospitals’ charges adjusted to the costs. We, therefore, have continued paying brachytherapy sources based on charges adjusted to cost for CY 2008. The status indicators of brachytherapy source HCPCS codes (except C2637) which were previously paid at charges adjusted to cost have remained “H” effective July 1, 2008 through December 31, 2008 for payment of brachytherapy sources at hospitals’ charges adjusted to their costs.

Table 2 – Comprehensive list of brachytherapy sources, payable as of January 1, 2009

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

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21. Billing for drugs, biologicals, and radiopharmaceuticals

a. Newly recognized HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals for CY 2009

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

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

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

For CY 2009, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These codes are listed in Table 3 below.

Table 3 – New HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals in CY 2009

CY2009 HCPCS Code	CY 2009 Short Descriptor	CY 2009 SI	CY 2009 APC
A9580	Sodium fluoride F-18	N	
C9245	Injection, romiplostim	G	9245
C9246	Inj, gadoxetate disodium	G	9246
C9247	Inj, iobenguane, I-123, dx	N	
C9248	Inj, clevidipine butyrate	G	9248
J0641	Levoleucovorin injection	K	1236
J3300	Triamcinolone A inj PRS-free	N	
Q4100	Skin substitute, NOS	N	
Q4111	Gammagraft skin sub	K	1252
J8705	Topotecan oral	K	1238

In addition, similar to CMS policy for CY 2008 where CMS began recognizing multiple HCPCS codes for the same drugs with different dosage descriptors, for CY 2009 CMS is newly recognizing the six HCPCS codes shown in Table 4 below. Payment for these newly recognized HCPCS drug codes for different doses of the same drugs is made on the same basis as payment for the previously recognized HCPCS codes for those drugs. Hospitals that may be burdened by reporting multiple HCPCS codes for the same drugs need not change their current billing practices for purposes of the OPPI, but hospitals that would like additional flexibility when billing for drugs with multiple HCPCS code dosages may report these codes.

Table 4 – HCPCS codes unrecognized in CY 2007 and CY 2008, associated recognized HCPCS codes, and status indicators for CY 2009

CY 2009 HCPCS Codes Previously Unrecognized	CY 2007 SI	CY 2009 Short Descriptor	Associated HCPCS Recognized in CY 2007	Final CY 2009 SI for Newly Recognized HCPCS Code
Q0165	B	Prochlorperazine maleate 10 mg	Q0164	N
Q0168	B	Dronabinol 5 mg oral	Q0167	N
Q0170	B	Promethazine HCl 25 mg oral	Q0169	N
Q0172	B	Chlorpromazine HCl 25 mg oral	Q0171	N
Q0176	B	Perphenazine 8 mg oral	Q0175	N
Q0178	B	Hydroxyzine pamoate 50 mg	Q0177	N

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Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2009. In addition, several temporary C-codes have been deleted effective December 31, 2008 and replaced with permanent HCPCS codes in CY 2009. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2009 HCPCS codes.

Table 5 – HCPCS code changes effective for certain drugs, biologicals, and radiopharmaceuticals in CY 2008

CY 2008 HCPCS Code	CY 2008 Long Descriptor	CY 2009 HCPCS Code	CY 2009 Long Descriptor
C9003	Palivizumab-RSV-IgM, per 50 mg	90378	Respiratory syncytial virus immune globulin (rsv-igim), for intramuscular use, 50 mg, each
J0348	Injection, anadulafungin, 1 mg	J0348	Injection, anidulafungin, 1 mg
C9241	Injection, doripenem, 10 mg	J1267	Injection, doripenem, 10 mg
C9242	Injection, fosaprepitant, 1 mg	J1453	Injection, fosaprepitant, 1 mg
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	J1459	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1751	Injection, iron dextran, 165, 50 mg	J1750	Injection, iron dextran, 50 mg
J1752	Injection, iron dextran 267, 50 mg		
Q4098	Injection, iron dextran, 50 mg		
C9237	Injection, lanreotide acetate, 1mg	J1930	Injection, lanreotide, 1 mg
C9238	Injection, levetiracetam, 10 mg	J1953	Injection, levetiracetam, 10 mg
C9244	Injection, regadenoson, 0.4 mg	J2785	Injection, regadenoson, 0.1 mg
J3100	Injection, tenecteplase, 50 mg	J3101	Injection, tenecteplase, 1 mg
Q4096	Injection, von willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. vwf:rc0	J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.
C9243	Injection, bendamustine hcl, 1 mg	J9033	Injection, bendamustine hcl, 1 mg
J9182	Etoposide, 100 mg	J9181	Etoposide 100 MG inj
C9240	Injection, ixabepilone, 1 mg	J9207	Injection, ixabepilone, 1 mg
C9239	Injection, temsirolimus, 1 mg	J9330	Injection, temsirolimus, 1 mg
J7340	Dermal and epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter	Q4101	Skin substitute, Apligraf, per square centimeter
J7341	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	Q4102	Skin substitute, Oasis Wound Matrix, per square centimeter
		Q4103	Skin substitute, Oasis Burn Matrix, per square centimeter
J7343	Dermal and epidermal, (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter	Q4104	Skin substitute, Integra Bilayer Matrix Wound Dressing (BMWD), per square centimeter
		Q4105	Skin substitute, Integra Dermal Regeneration Template (DRT), per square centimeter

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CY 2008 HCPCS Code	CY 2008 Long Descriptor	CY 2009 HCPCS Code	CY 2009 Long Descriptor
J7342	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	Q4106	Skin substitute, Dermagraft, per square centimeter
J7344	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter	Q4107	Skin substitute, Graft Jacket, per square centimeter
J7347	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Integra Matrix), per sq. cm.	Q4108	Skin substitute, Integra Matrix, per square centimeter
J7348	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (TissueMend), per sq. cm.	Q4109	Skin substitute, Tissuemend, per square centimeter
J7349	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (PriMatrix), per sq. cm.	Q4110	Skin substitute, Primatrix, per square centimeter
J7346	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolically active elements, 1 cc	Q4112	Allograft, Cymetra, Injectable, 1cc
		Q4113	Allograft, Graft Jacket Express, injectable, 1cc
C9357	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	Q4114	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc

b. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2009

For CY 2009, payment for nonpass-through drugs and biologicals is made at a single rate of ASP+4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In CY 2009, a single payment of ASP+6 percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Note that for the first quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition program (CAP) rate, as the CAP program is suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2009, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute. In the CY 2009 OP/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2009, payment rates for many drugs and biologicals have changed from the values published in the CY 2009 OP/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2008. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2009 release of the OP/ASC PRICER. CMS is not publishing the updated payment rates in this Change Request implementing the January 2009 update of the OP/ASC. However, the updated payment rates effective January 1, 2009 may be found in the January 2009 update of the OP/ASC Addendum A and Addendum B on the CMS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp>.

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c. Updated payment rates for certain HCPCS codes effective April 1, 2008, through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 OPSS PRICER. The corrected payment rates are listed below and have been installed in the January 2009 OPSS PRICER, effective for services furnished on April 1, 2008, through implementation of the July 2008 update. Where claims were processed incorrectly, your Medicare contractor will make adjustments if you bring such claims to their attention.

Table 6 – Updated payment rates for certain HCPCS codes effective April 1, 2008, through June 30, 2008

HCPCS Code	CY 2008 SI	CY 2008 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	\$12.71	\$2.54
J1626	K	0764	Granisetron HCl injection	\$5.99	\$1.20
J2405	K	0768	Ondansetron hcl injection	\$0.23	\$0.05
J2730	K	1023	Pralidoxime chloride inj	\$83.17	\$16.63
J9208	K	0831	Ifosfomide injection	\$36.77	\$7.35
J9209	K	0732	Mesna injection	\$7.81	\$1.56

d. Updated payment rates for certain HCPCS codes Effective July 1, 2008, through September 30, 2008

The payment rates for several HCPCS codes were incorrect in the July 2008 OPSS PRICER. The corrected payment rates are listed below and have been installed in the January 2009 OPSS PRICER, effective for services furnished on July 1, 2008 through implementation of the October 2008 update. Where claims were processed incorrectly, your Medicare contractor will make adjustments if you bring such claims to their attention.

Table 7 – Updated payment rates for certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

CY 2008 HCPCS Code	CY 2008 SI	CY 2008 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	\$11.57	\$2.31
J1566	K	2731	Immune globulin, powder	\$28.37	\$5.67
J1569	K	0944	Gammagard liquid injection	\$34.66	\$6.93
J2730	K	1023	Pralidoxime chloride inj	\$84.90	\$16.98
J7190	K	0925	Factor viii	\$0.85	\$0.17
J7192	K	0927	Factor viii recombinant	\$1.12	\$0.22
J7198	K	0929	Anti-inhibitor	\$1.47	\$0.29
J8510	K	7015	Oral busulfan	\$2.55	\$0.51
J9208	K	0831	Ifosfomide injection	\$34.04	\$6.81

e. Updated payment rates for certain HCPCS codes effective October 1, 2008, through December 31, 2008

The payment rates for certain HCPCS codes were incorrect in the October 2008 OPSS PRICER. The corrected payment rates are listed below and have been installed in the January 2009 OPSS PRICER, effective for services furnished on October 1, 2008 through implementation of the January 2009 update. Where claims were processed incorrectly, your Medicare contractor will make adjustments if you bring such claims to their attention.

Table 8 – Updated payment rates for certain HCPCS codes effective October 1, 2008, through December 31, 2008

CY 2008 HCPCS Code	CY 2008 SI	CY 2008 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1568	K	0943	Octagam injection	\$35.58	\$7.12
J2323	G	9126	Natalizumab injection	\$7.51	\$1.49

f. Correct reporting of biologicals when used as implantable devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPSS payment for the biological is packaged into the payment for the associated procedure.

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

g. Correct reporting of units for drugs

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

h. Vaccines approved by FDA

In July 2007, the CPT Editorial Panel released two vaccine codes on the American Medical Association Web site, specifically CPT codes 90681 and 90696 that were implemented in January 2008. Although the vaccines associated with these codes were not approved by the Food and Drug Administration (FDA) until April 2008 (for CPT code 90681) and June 2008 (for CPT code 90696), and we did not assign the codes to separate APCs under the OPSS until the January 2009 update, their payments are retroactive to the FDA approval dates. Below in Table 9 are the long descriptors for CPT codes 90681 and 90696 and their APC assignments. Also, note that the “Effective Date of Payment Rate” listed in Table 9 reflects the specific date the vaccine received its FDA approval. Items that are reported using these HCPCS codes with dates of service prior to the date of the FDA approval, will be rejected.

Table 9 – New Vaccine Codes

HCPCS Code	CY 2008 SI	CY 2008 APC	Long Descriptor	Payment Rate	Effective Date of Payment Rate
90681	K	1239	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	\$106.60	4/3/2008
90696	K	1219	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	\$49.92	6/24/2008

i. – Payment for therapeutic radiopharmaceuticals

The MIPPA of 2008 requires CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008, through December 31, 2009, at hospitals’ charges adjusted to the costs. Therefore, the status indicators of therapeutic radiopharmaceutical HCPCS codes will remain “H” effective July 1, 2008, through December 31, 2009, to indicate payment will be made for therapeutic radiopharmaceuticals at hospitals’ charges adjusted to their costs.

Table 10 – Therapeutic radiopharmaceuticals paid at charges adjusted to cost from July 1, 2008 through December 31, 2009

CY 2009 HCPCS Code	CY 2009 Long Descriptor	CY 2009 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H

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CY 2009 HCPCS Code	CY 2009 Long Descriptor	CY 2009 SI
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H

j. – Reporting of outpatient diagnostic nuclear medicine procedures

Effective January 1, 2008 under the OPSS, payment for all nonpass-through diagnostic radiopharmaceuticals is packaged into payment for their associated nuclear medicine procedures and this payment methodology is continuing for CY 2009. In order to ensure that CMS captures appropriate diagnostic radiopharmaceutical costs for future rate-setting purposes, CMS implemented nuclear medicine procedure-to-radiolabeled product edits in the I/OCE effective January 2008 that required a radiolabeled product to be present on the same claim as a nuclear medicine procedure for payment under the OPSS to be made. These edits have been revised quarterly, based on information provided to us by members of the public with regard to certain clinical scenarios.

Most recently, for the October 2008 update CMS created HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay. This HCPCS code is assigned status indicator “N” because no separate payment is made for the code under the OPSS. The effective date of the code is January 1, 2008, the date the nuclear medicine procedure-to-radiolabeled product edits were initially implemented. Because the Medicare claims processing system requires that there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than \$1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code, which should always accompany the reporting of HCPCS code C9898. HCPCS code C9898 should never be reported on a claim without a diagnostic nuclear medicine procedure that is subject to the nuclear medicine procedure-to-radiolabeled product edits.

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

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

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

22. Drug administration services

Several of the CY 2008 CPT codes for drug administration services have been renumbered or edited for CY 2009. Both the CY 2008 CPT codes and the CY 2009 CPT codes, along with the CY 2009 long code descriptors, are shown in Table 11 below.

Table 11–Drug administration CPT and HCPCS codes effective CY 2009

2008 CPT code	2009 CPT code	2009 Long descriptor
90760	96360	<i>Intravenous infusion, hydration; initial, 31 minutes to 1 hour</i>
90761	96361	<i>Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)</i>
90765	96365	<i>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour</i>
90766	96366	<i>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)</i>
90767	96367	<i>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)</i>

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2008 CPT code	2009 CPT code	2009 Long descriptor
90769	96369	<i>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)</i>
90770	96370	<i>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)</i>
90771	96371	<i>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)</i>
90772	96372	<i>Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</i>
90773	96373	<i>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial</i>
90774	96374	<i>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug</i>
90775	96375	<i>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)</i>
90779	96379	<i>Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion</i>

23. Billing for cardiac echocardiography services

a. – Cardiac echocardiography without contrast

Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350). We note that for CY 2009, the AMA revised several CPT codes in the 93000 series to more specifically describe particular services provided during echocardiography procedures. These new and revised codes are listed in Table 12 below.

Table 12 – New and revised CY 2009 electrocardiography CPT codes

CY 2009 CPT	Long Descriptor	New or Revised for CY 2009
93306	<i>Echocardiography, transthoracic real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography</i>	New
93307	<i>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography</i>	Revised
93308	<i>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study</i>	Revised
93350	<i>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report</i>	Revised
93351	<i>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision</i>	New
93352	<i>Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography) (Use 93352 in conjunction with 93350 or 93351)</i>	New

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b. – Cardiac Echocardiography with contrast

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 13 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. CPT codes should be used for without contrast studies only. In the without contrast followed by with contrast case, hospitals should not bill the CPT code for a without contrast study in addition to the C-code when they provide a without contrast followed by with contrast study.

Table 13 – HCPCS codes for echocardiograms with contrast

HCPCS	Long Descriptor	New or Revised for CY 2009
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete	No change
C8922	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study	No change
C8923	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Revised
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Revised
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	No change
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	No change
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	No change
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	Revised
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	New
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision	New

24. Changes to OPPTS PRICER logic

- a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2009. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and services paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173.
- b. New OPPTS payment rates and coinsurance amounts will be effective January 1, 2009. All coinsurance rates will be limited to a maximum of 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of \$1,068.

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- c. For hospital outlier payments under OPSS, there will be no change in the multiple threshold of 1.75 for 2009. This threshold of 1.75 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is $(\text{cost} - (\text{APC payment} \times 1.75)) / 2$.
- d. However, there will be a change in the fixed-dollar threshold in CY 2009. The estimated cost of service must be greater than the APC payment amount plus \$1,800 in order to qualify for outlier payments. The previous fixed-dollar threshold was \$1,575.
- e. The charges for services included in a composite payment will be aggregated to one line using Composite Adjustment Flags (CAF) 01-ZZ for each composite on a claim, including partial hospitalization composite APCs 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), and mental health services composite APC 0034 (Mental Health Services Composite), and will be considered the total charge for each composite service when determining eligibility for outlier payments. (Note: Effective January 1, 2009, the Payment Adjustment Flag values of 91-99 are no longer valid; thus, they are no longer used by PRICER to identify composites. See CR 6056 for more information.)
- f. Payment will be made through APC 0034 if the total payment amount for mental health services provided on one day would otherwise exceed payment for APC 0173.
- g. For outliers for community mental health centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2009. This threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is $(\text{cost} - (\text{APC payment} \times 3.4)) / 2$.
- h. The OPSS PRICER will continue to respond to claim lines that have an I/OCE Payment Adjustment Flag (PAF) #7 (Item provided without cost to provider) applied to the line. The OPSS I/OCE will apply the PAF #7 whenever a claim line has a HCPCS C code and procedure code on the lists of codes subject to this adjustment and an FB modifier. When OPSS PRICER finds a PAF #7 for a line item, it will apply the offset reduction to offset the device portion from the APC payment, which includes payment for packaged devices. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. OPSS PRICER will apply the offset to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the offset reduction.
- i. The OPSS PRICER will continue to respond to lines that have an I/OCE Payment Adjustment Flag (PAF) #8 (i.e., Item provided with partial credit to provider) applied to the line. The OPSS I/OCE will apply the PAF #8 whenever a claim line has a HCPCS C-code and procedure code on the lists of codes subject to this adjustment and a modifier FC. When OPSS PRICER finds a PAF #8 for a line item, it will apply 50 percent of the dollar offset reduction to offset the device portion from the APC payment, which includes payment for packaged devices. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. OPSS PRICER will apply the offset to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the offset reduction.
- j. Effective January 1, 2009, brachytherapy sources will be paid at charges adjusted to cost, as required by the MIPPA. Additionally, status indicator "U" will be used to denote brachytherapy sources for payment purposes.
- k. Effective January 1, 2009, status indicator "R" will be used to denote blood and blood products for payment purposes.
- l. Effective January 1, 2009, no items are eligible for pass through payment in the OPSS PRICER logic. There are no associated APC offset amounts or specific logic assigning device payment to associated APC payment for determining outlier eligibility and payment.
- m. Effective January 1, 2009, the OPSS PRICER will apply a reduced update ratio of 0.981 to the payment and copayment for hospitals that fail to meet their reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

25. Coverage determinations

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

January 2009 update of the hospital outpatient prospective payment system (continued)

Additional Information

Revised portions of the *Medicare Claims Processing* and *Medicare Benefit Policy* manuals are attached to CR 6320. There are two transmittals associated with CR 6320. One is Transmittal 1657, which contains the changes to the *Medicare Claims Processing Manual* and is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1657CP.pdf>.

The other Transmittal is Transmittal 101, which has the changes to the *Medicare Benefit Policy Manual* and is on the CMS site at <http://www.cms.hhs.gov/Transmittals/downloads/R101BP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6320

Related Change Request (CR) Number: 6320

Related CR Release Date: December 31, 2008 (R1657CP) and January 16, 2009 (R101BP)

Related CR Transmittal Number: R1657CP and R101BP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1657, CR 6320

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Revised quarterly provider specific files now available

The January 2009 quarterly provider specific files (PSFs) in statistical analysis system (SAS) format have been revised and are now available on the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp in the Downloads section. If you use the provider specific SAS file data, please go to the page above and download the latest version of the PSFs.

Note: These are the quarterly data sets for the “Provider Specific Data for Public Use in SAS Format.”

The January 2009 quarterly provider specific files (PSFs) in text format have been revised and are now available on the CMS Web site at http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp in the Downloads section. If you use the provider specific text file data, please go to the page above and download the latest versions of the PSFs.

Note: These are the quarterly data sets for the “Provider Specific Data for Public Use in Text Format.” ❖

Source: CMS PERL 200901-33

Application of the hospital outpatient quality data reporting program under the hospital outpatient prospective payment system

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 to reflect that change request (CR) 6320 made a correction to CR 6072, on which this article is based. The correction to CR6072 was to include blood ambulatory payment classifications (APCs) with status indicator “R” under the application of the quality reporting ratio where appropriate. The status indicator “R” has been added to the bold printed language under the Background section of this article. All other information remains the same. The MLN Matters article MM6072 was published in the November 2008 *Medicare A Bulletin* (page 35).

Provider types affected

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

Provider action needed STOP – Impact to you

This article is based on change request (CR) 6072 regarding application of the hospital outpatient quality data reporting program to services paid under the hospital outpatient prospective payment system (OPPS), effective for services provided on or after January 1, 2009.

Application of the hospital outpatient quality data reporting program under the hospital outpatient PPS (continued)

CAUTION – what you need to know

Effective for OPSS services furnished on or after January 1, 2009, ‘subsection (d) hospitals’ that have failed to submit timely outpatient hospital quality data as required in the Social Security Act (Section 1833(t)(17) (A)) will receive payment under the OPSS that **reflects a two percent deduction from the annual OPSS update** for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edits. Hospitals that are not required to submit quality data (i.e. that are not ‘subsection (d) hospitals’) will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPSS (e.g. Indian health service hospitals).

GO – what you need to do

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

Background

As a condition for receiving the full market basket update on their inpatient prospective payment system (IPPS) payments, all hospitals defined as ‘subsection (d) hospitals’, are required to report hospital quality data:

- In a timely manner
- In a way that passes the Centers for Medicare & Medicaid Services (CMS) validation edits for inpatients receiving services in the hospital.

Effective for services furnished on or after January 1, 2009, this policy will also apply to services paid under OPSS to ‘subsection (d) hospitals’.

‘Subsection (d) hospitals’ have the same definition for hospitals paid under the OPSS as for hospitals paid under the inpatient PPS. Specifically, ‘subsection (d) hospitals’ are defined in the Social Security Act (Section 1886(d)(1)(B); http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet) as hospitals that are located in the fifty states or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children’s and cancer hospitals or hospital units. In other words, the provision does not apply to hospitals and hospital units excluded from the IPPS, or to hospitals located in Maryland, Puerto Rico, or the U.S. territories.

CR 6072 announces that, effective for OPSS services furnished on or after January 1, 2009, **‘subsection (d) hospitals’ that have failed to submit timely outpatient hospital quality data** as required in the Social Security Act

(Section 1833(t)(17)(A); http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) **will receive payment under the OPSS that reflects a two percent deduction from the annual OPSS update for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edit. Where hospitals are required to report the quality data and fail to do so, the OPSS PRICER will assign a new return code of 11 (Reduced for absent quality reporting) when a payment APC on a line has a status indicator equal to P, R, or S (if APC is not 1491-1537), T (if APC is not 1539-1574), V, or X.**

Hospitals that are not required to submit quality data (i.e. that are not ‘subsection (d) hospitals’) will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPSS (e.g. Indian health service hospitals).

CMS will send your FI or MAC a file of hospitals to which the reduction will apply as soon as the list is available. This is expected to be on or about December 1 of each year. Should a ‘subsection (d) hospital’ later be determined to have met the criteria after publication of this list, their status will be changed and FIs/MACs will be notified.

For new hospitals, FIs/MACs will provide information to CMS (or a CMS-designated contractor) to allow contact with the new facilities to inform them of the Hospital Quality Initiative.

Additional information

The official instruction, CR 6072, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R368OTN.pdf>.

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

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

MLN Matters Number: MM6072 – Revised
 Related Change Request (CR) Number: 6072
 Related CR Release Date: August 15, 2008
 Related CR Transmittal Number: R368OTN
 Effective Date: January 1, 2009
 Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 368, CR 6072

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Home health prospective payment system refinement and rate update for calendar year 2009

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

Provider Types Affected

Home health agencies (HHA) who bill regional home health intermediaries (RHHI) for services provided to Medicare beneficiaries.

Provider Action Needed

Change request (CR) 6341, from which this article is taken, updates the 60 day national episode rates and the national per-visit amounts under the home health prospective payment system (HH PPS) for calendar year (CY) 2009. Note that for CY 2009, Medicare home health payments for HHAs that report quality data (described below) will be increased by 2.9 percent, while payments for those HHAs that do not report quality data will be increased 0.9 percent. Be sure billing staff are aware that the CY 2009 rates apply for episodes with claim statement “Through” dates on or after January 1, 2009, and on or before December 31, 2009.

Background

Section 5201 of the Deficit Reduction Act (DRA) requires that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2009. CR 6341, from which this article is taken, announces that this increase for CY 2009 is 2.9 percent (effective January 1, 2009). CR 6341 also discusses the HHAs’ reporting of quality data, since Section 1895 (b)(3)(B)(v) of the Social Security Act requires that HHAs report quality data or be subject to a two percent reduction to the home health market basket percentage increase applicable to HH PPS payments for CY 2009.

To establish new payments for CY 2009, the Centers for Medicare & Medicaid Services (CMS) started with the CY 2008 national standardized 60-day episode payment of \$2,270.32 and increased that by the home health market basket update for CY 2009 (2.9 percent). This figure is then reduced by the 2.75 percent case-mix adjustment. Table 1 below shows the calculations, which yield a CY 2009, updated national standardized 60-day episode payment rate of \$2,271.92. These payments are further adjusted by the individual episode’s case-mix weight and wage index.

The following two tables show the payments to HHAs that **do** report the required quality data:

Table 1

National 60-day episode amounts updated by the home health market basket update for CY 2009, before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary				
Total CY 2008 national standardized 60-day episode payment rate	Multiply by the home health market basket update (2.9 percent)	Updated national standardized 60-day episode payment rate	Reduce by 2.75 percent for nominal change in case-mix	CY 2009 national standardized 60-day episode payment rate
\$2,270.32	X 1.029	\$2,336.16	X 0.9725	\$2,271.92

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs) and outlier payments. The national per-visit amounts are as follows:

Table 2

National per-visit amounts for LUPAs (not including the increase in payment for a beneficiary’s only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the home health market basket update for CY 2009, before wage index adjustment based on the site of service for the beneficiary			
Home health discipline	CY 2008 per-visit rate	Multiply by the CY 2009 home health market basket (2.9 percent)	CY 2009 per-visit rate (CY 2008 rate multiplied by 1.029)
Home health aide	\$47.51	X 1.029	\$48.89
Medical social services	\$168.17	X 1.029	\$173.05
Occupational therapy	\$115.48	X 1.029	\$118.83
Physical therapy	\$114.71	X 1.029	\$118.04
Skilled nursing	\$104.91	X 1.029	\$107.95
Speech-language pathology	\$124.65	X 1.029	\$128.26

The following two tables show the rates for HHAs that **do not** report the required quality data:

Home health prospective payment system refinement and rate update for calendar year 2009 (continued)

Table 3

For HHAs that do not submit the required quality data -- national 60-day episode amounts updated by the home health market basket update for CY 2009 minus two percent, before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary				
Total CY 2008 national standardized 60-day episode payment rate	Multiply by the home health market basket update (2.9 percent) minus two percent	Updated national standardized 60-day episode payment for HHAs that do not submit required quality data	Reduce by 2.75 percent for nominal change in case-mix	CY 2009 national standardized 60-day episode payment for HHAs that do not submit required quality data
\$2,270.32	X 1.009	\$2,290.75	X 0.9725	\$2,227.75

Table 4

For HHAs that do not submit the required quality data -- national per-visit amounts for LUPAs (not including the increase in payment for a beneficiary's only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the home health market basket update for CY 2009 minus two percent, before wage index adjustment based on the site of service for the beneficiary			
Home health discipline	CY 2008 per-visit rate	Multiply by the home health market basket update (2.9 percent) minus 2 percent	CY 2009 per-visit rate
Home health aide	\$47.51	X 1.009	\$47.94
Medical social services	\$168.17	X 1.009	\$169.68
Occupational therapy	\$115.48	X 1.009	\$116.52
Physical therapy	\$114.71	X 1.009	\$115.74
Skilled nursing	\$104.91	X 1.009	\$105.85
Speech-language pathology	\$124.65	X 1.009	\$125

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The Table 2 and Table 4 per-visit rates noted above are before that additional payment is added to the LUPA amount. For CY 2008, that amount was \$87.93. This additional LUPA amount is updated by the home health market basket percentage update. Consequently, for CY 2009, the additional amount paid for LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode is \$90.48 (\$87.93 x 1.029).

As Medicare did in the CY 2008 HH PPS final rule with comment, payments for nonroutine medical supplies (NRS) are updated by the home health market basket and reduced by the 2.75 percent reduction to the rates through the updating of the NRS conversion factor. NRS payments are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2009 payments, the NRS conversion factor is updated by the CY 2009 home health market basket update of 2.9 percent and reduced by the 2.75 percent reduction to the rates. The NRS conversion factor for CY 2008 was \$52.35. Consequently, for CY 2009, the NRS conversion factor is \$52.39 (\$52.35 x (1.029 * (1 - 0.0275))).

The payment amounts for the various severity levels based on the updated conversion factor are calculated in Table 5.

Table 5

Relative weights for the six-severity NRS system			
Severity level	Points (scoring)	Relative weight	NRS payment amount
1	0	0.2698	\$14.13
2	1 to 14	0.9742	\$51.04
3	15 to 27	2.6712	\$139.94
4	28 to 48	3.9686	\$207.91
5	49 to 98	6.1198	\$320.62
6	99+	10.5254	\$551.43

These changes will be implemented through the home health PRICER software found in your RHHI's claims processing system. Your RHHI will contact you if you are to receive reduced payments for CY 2009.

Home health prospective payment system refinement and rate update for calendar year 2009 (continued)

Additional Information

The official instruction (CR 6341) issued to your Medicare RHHI/MAC is available at on the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1662CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6341

Related Change Request (CR) Number: 6341

Related CR Release Date: January 7, 2009

Related CR Transmittal Number: R1662CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04 Transmittal 1662, CR 6345

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ELECTRONIC DATA INTERCHANGE

Instructions on using ANSI X12 837 institutional segments for Medicare secondary payer Part A claims

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

Provider types affected

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

Stop – Impact to you

This article is based on change request (CR) 6275 which contains clarifying information on how Medicare uses data reported in American National Standards Institute (ANSI) ASC X12N 837 institutional claim adjustment segments (CAS) for Medicare secondary payer (MSP) Part A claims.

Caution – What you need to know

CR 6275 alerts Medicare contractors to the Medicare system processes necessary to derive MSP payment calculations from incoming ANSI ASC X12N 837 4010-A1 claims transactions. CR 6275 only affects providers submitting Part A claims.

Go – What you need to do

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health & Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available on the Internet at <http://www.wpc-edi.com>.

This article is to remind you to include CAS related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6275 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements.
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 institutional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, a.k.a your contractual obligation, you must identify this amount as value code 44 in the 2300 HI value information. This amount is also known as the obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be found in the *CMS Internet Only Manuals* 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33.

Additional information

The official instruction, CR 6275, issued to your FI, MAC, and RHHI regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R63MSP.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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6275
 Related Change Request (CR) Number: 6275
 Related CR Release Date: December 19, 2008
 Related CR Transmittal Number: R63MSP
 Effective Date: July 1, 2009
 Implementation Date: July 6, 2009

Source: CMS Pub. 100-05, Transmittal 63, CR 6275

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Final ICD-10 code sets and updated electronic transaction standard rules

The U.S. Department of Health & Human Services (HHS) recently released two final rules that will facilitate the United States' ongoing transition to an electronic health care environment through adoption of a new generation of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

The first final rule, with a compliance date of October 1, 2013, replaces the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets. The second final rule adopts an updated X12 standard, version 5010, for certain electronic health care transactions, an updated version of the National Council for Prescription Drug Programs (NCPDP) standard, version D.0, for electronic pharmacy-related transactions, and a standard for Medicaid pharmacy subrogation transactions. Version 5010 includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Version 5010 also accommodates the use of the ICD-10 code sets, which are not supported by version 4010/4010A1, the current X12 standard.

"These regulations will move the nation toward a more efficient, quality-focused health care system by helping

accelerate the widespread adoption of health information technology," HHS Secretary Mike Leavitt said. "The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities. The updated X12 transaction standards, version 5010, provide the framework needed to support the ICD-10 codes."

The ICD-10 rule titled HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS is available in text format at <http://edocket.access.gpo.gov/2009/E9-743.htm> and in PDF at <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>.

The updated X12 transaction standards, version 5010, rule titled Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards is available in text format at <http://edocket.access.gpo.gov/2009/E9-740.htm> and in PDF at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>.

The fact sheet describing both rules is available at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?> ❖

Source: CMS PERL 200901-30

January 2009 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], Medicare administrative contractors [A/B MAC], and durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 6328, 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 transactions.

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 6328 updates the changes in the claim status codes and claim status category codes from the June,

2008 committee meeting. These updates were posted at <http://www.wpc-edi.com/content/view/180/223/> on June 30, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by January 5, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional information

The official instruction (CR 6328) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1656CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6328
Related Change Request (CR) Number: 6328
Related CR Release Date: December 31, 2008
Related CR Transmittal Number: R1656CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1656, CR 6328

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

April 2009 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], Medicare administrative contractors [A/B MAC], and durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 6325, from which this article is taken, reminds providers of the periodic updates to the claim category and claim status 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 transactions.

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 6325 updates the changes in the claim status codes and claim status category codes from the

September, 2008 committee meeting. These updates were posted at <http://www.wpc-edi.com/content/view/180/223/> on November 1, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by April 6, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional information

The official instruction (CR 6325) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1670CP.pdf> on the CMS Web site.

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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6325
 Related Change Request (CR) #: 6325
 Related CR Release Date: January 16, 2009
 Effective Date: April 1, 2009
 Related CR Transmittal #: R1670CP
 Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1670, CR 6325

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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 contractor. 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.medicare.fcs.com>, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events January 2009 – May 2009

Topic: Introduction to the Provider Data Summary report

When: Tuesday, March 3, 2009
 Time: 11:30 a.m. – 12:30 p.m. Eastern Time
 Type of Event: Webcast

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

When: Wednesday, March 11, 2009
 Time: 11:30 a.m. – 12:30 p.m. Eastern Time
 Type of Event: Webcast

Topics – Provider enrollment for new physicians, residents, and interns (Part A and B)

When: Wednesday, March 12, 2009
 Time: 11:30 a.m. – 1:00 p.m. Eastern Time
 Type of Event: Webcast

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

When: Wednesday, May 13, 2009
 Time: 11:30 a.m. – 12:30 p.m. Eastern Time
 Type of Event: Webcast

Two easy ways to register

Online – Visit our provider training Web site at www.fcsomedicaretraining.com, log on to your account 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 by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

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.

Tips for using the FCSO provider training Web site

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

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

Select **Register** in the Options column located next to the specific course listed on the Instructor-Led Training (ILT) schedule page. For further assistance, contact FCSO Medicare training help desk at 1-866-756-9160 or send an e-mail 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: _____

Keep checking our Web site, www.medicare.fcsso.com, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers. ❖

PREVENTIVE SERVICES

January is National Glaucoma Awareness Month

In recognition of National Glaucoma Awareness Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of a comprehensive annual glaucoma screening exam for seniors and others with Medicare at high risk for developing glaucoma.

Glaucoma is a leading cause of blindness in the United States and while anyone can develop glaucoma, the risk of glaucoma increases with age. Early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Medicare coverage

Medicare beneficiaries who belong to one of the following high risk groups are eligible for an annual glaucoma screening covered by Medicare:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What you can do

As a health care professional who provides care to seniors and others with Medicare, you can help protect the vision of your Medicare patients who may be at high risk for glaucoma by educating them about their risk factors and reminding them of the importance of getting an annual glaucoma screening exam covered by Medicare. Your reminder and referral for a glaucoma screening exam can help provide eligible Medicare beneficiaries with peace of mind and safeguard their vision.

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their

staff learn more about coverage, coding, billing, and reimbursement for preventive services and screenings covered by Medicare.

The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider-specific educational products related to preventive services.

The Web page is located on the CMS Web site at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.

Glaucoma Screening Brochure – this tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of glaucoma screening services. To view online go to the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf>.

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

The CMS Web site – provides information for preventive services covered by Medicare. Go to <http://www.cms.hhs.gov>, select “Medicare”, and scroll down to the “Prevention” section.

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

For more information about glaucoma, visit The National Eye Institute <http://www.nei.nih.gov/index.asp>.

For more information about National Glaucoma Awareness Month, please visit <http://www.preventblindness.org/>.

Thank you for joining CMS in the effort to educate beneficiaries about glaucoma and the importance of early detection by encouraging them to take advantage of the annual glaucoma screening benefit covered by Medicare. You are helping CMS protect the vision of Medicare beneficiaries who are at higher risk for glaucoma. ❖

Source: CMS PERL 200901-07

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 Medicare contractor. 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.medicare.fcso.com>, select Florida Provider, click on the “eNews” link located on the upper-right-hand corner of the page and follow the prompts.

Products on preventive services available from the *Medicare Learning Network*

Products on preventive services are now available for ordering free-of-charge from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network (MLN)*.

The *ABCs of Providing the Initial Preventive Physical Examination Quick Reference* Information chart (January 2009) is a resource tool that is now available as either a two-sided laminated chart or as a tear-off pad. It may be used by Medicare fee-for-service physicians and qualified nonphysician practitioners as a guide when providing the initial preventive physical examination (IPPE), which is also known as the “Welcome to Medicare” physical exam or the “Welcome to Medicare” visit. This reference guide identifies the components and elements of the IPPE; provides eligibility requirements and procedure codes to use when filing claims, FAQs, and suggestions for preparing patients for the IPPE; and lists references for additional information. To view, download, and print this resource, please go to the CMS MLN at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf. To order the laminated chart or tear-off pad free-of-charge, visit <http://www.cms.hhs.gov/MLNProducts/>, scroll down to *Related Links Inside CMS*, and select *MLN Product Ordering Page*.

The *Medicare Preventive Services Quick Reference* Information chart (January 2009) is a two-sided laminated chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare preventive services. To view, download, and print this resource, please go to the CMS MLN at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.

To order these two products free-of-charge, visit http://www.cms.hhs.gov/MLNProducts/01_Overview.asp, scroll down to *Related Links Inside CMS*, and select *MLN Product Ordering Page*. ❖

Source: CMS PERL 200901-35 and PERL 200901-49

OTHER EDUCATIONAL RESOURCES

Update to the Medicare Billing Information for Rural Providers

The Centers for Medicare & Medicaid Services (CMS) publication *Medicare Billing Information for Rural Providers, Suppliers, and Physicians* (revised October 2008) is comprised of charts that provide Medicare billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, critical access hospitals, and swing beds. A printed copy of this publication is now available from the CMS *Medicare Learning Network*. To place your order, visit http://www.cms.hhs.gov/MLNProducts/01_Overview.asp, scroll down to *Related Links Inside CMS*, and select *MLN Product Ordering Page*. ❖

Source: CMS PERL 200901-13

The Expanded Benefits Brochure available

The *Expanded Benefits Brochure* (January 2009) is now available in downloadable format. This tri-fold brochure provides health care professionals with an overview of Medicare coverage of three preventive services: the initial preventive physical examination (IPPE) (also known as the Welcome to Medicare Physical exam or the Welcome to Medicare visit), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. To view, download, and print the brochure please go to the CMS *Medicare Learning Network (MLN)* at http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf. ❖

Source: CMS PERL 200901-08

Update to the Five-Star Quality Rating Technical Users' Guide

A new version of the *Five-Star Quality Rating Technical Users' Guide* and an accompanying *Summary of Updates to the Technical Users' Guide* document are available on the Five-Star Quality Rating System Web page. For the latest version of the manual, see http://www.cms.hhs.gov/CertificationandCompliance/13_FSQRS.asp#TopOfPage. ❖

Source: CMS PERL 200901-37

Order Form – Medicare Part A Materials

The following materials are available for purchase. To order, please complete and submit this form along with your check/ money order payable to: **FCSO – account number 40-500-150.**

Number Ordered	Item	Account Number	Cost per Item
_____	<p>Medicare A Bulletin Subscriptions – The <i>Medicare A Bulletin</i> is available free of charge online at http://www.fcsso.com. Hardcopy or CD-ROM distribution is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue.</p> <p>Beginning with publications issued after June 1, 2003, providers that meet the above criteria must register with our office (see May 2008 <i>Medicare A Bulletin</i> page 4) to receive the <i>Bulletin</i> in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason is given indicating why the electronic publication available free-of-charge on the Internet cannot be used.</p> <p>Non-Medicare providers (e.g., billing agencies, consultants, software vendors, etc.) or providers that need additional copies at other office-facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published from October 2008 through September 2009 (back issues sent upon receipt of the order). Please check here if this will be a:</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Subscription renewal or <input type="checkbox"/> New subscription </p>	40-500-150	<p style="text-align: center;">\$33.00 (Hardcopy)</p> <p style="text-align: center;">\$55.00 (CD-ROM)</p>

Subtotal \$ _____

Tax (add % for your area) \$ _____

Total \$ _____

Mail this form with payment to:
First Coast Service Options, Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Attention: _____ Area Code/Telephone Number: _____

**Please make check/money order payable to: FCSO Account #40-500-150
 (CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)**

**ALL ORDERS MUST BE PREPAID –
 DO NOT FAX - PLEASE PRINT LEGIBLY**

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

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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

Seminar Registration Hotline 1-904-791-8103

Seminar Registration Fax Number 1-904-361-0407

ELECTRONIC CLAIM FILING “DDE Startup”

Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY Home Health Agency Claims Hospice Claims

Palmetto Government Benefit
Administrators – Gulf Coast
34650 US Highway 19 North,
Suite 202
Palm Harbour, FL 34684-2156

RAILROAD MEDICARE

Railroad Retiree Medical Claims
Palmetto Government Benefit
Administrators
P. O. Box 10066
Augusta, GA 30999-0001

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 amend-
ed)

Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimburse-
ment (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 Government Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS

Customer Service Center Toll-
Free

1-888-664-4112
Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY

Customer Service Center Toll-
Free

1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility

1-904-791-8131

Electronic Remittance Advice

1-904-791-6865

Direct Data Entry (DDE) Support

1-904-791-8131

PC-ACE Support

1-904-355-0313

Testing

1-904-791-6865

Help Desk

(Confirmation/Transmission)

1-904-905-8880

Medicare Web sites

PROVIDERS

Florida Medicare Contractor
www.medicare.fcso.com
Centers for Medicare & Medicaid
Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid
Services
www.medicare.gov



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦

