MEDICARE A Bulletin

A NEWSLETTER FOR MAC J9 PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued after October 1, 1997, are available at no-cost from our provider Web site at *http://medicare.fcso.com/*.

Routing Suggestions:

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

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

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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, Puerto Rico and U.S. Virgin Islands in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

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

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy. 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:

- Sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities are included in the first part of the publication.
- 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.)
- 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.
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- 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.

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 electronic mail to ensure timely notification of all additions to the QPU. ❖

GENERAL INFORMATION

Type of bill for federally qualified health centers from 73x to 77x

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

Provider types affected

Federally qualified health centers (FQHCs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A Medicare administrative contractors [A MACs]) for services provided to Medicare beneficiaries.

Provider action needed

STOP – Impact to you

On August 5, 2008, the National Uniform Billing Committee (NUBC) voted to change the type of bill (TOB) that is used to identify FQHCs from 73x to 77x effective April 1, 2010.

CAUTION – What you need to know

Medicare fee-for-service payer and provider systems will be updated to accommodate this change of bill type.

GO – What you need to do

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

Background

On August 5, 2008, the NUBC voted to change the TOB that is used to identify FQHCs from 73x to 77x effective April 1, 2010. The NUBC created the new TOB for FQHCs because TOB 73x, which has historically been used for FQHCs, is **technically designed to apply to free-standing clinics of any kind.**

Note that when billing the FI or A MAC for FQHC service, TOB 77x will be used for both:

- Free-standing FQHCs
- Provider-based FQHCs.

For dates of service (DOS) on or after April 1, 2010, TOB 73x will continue to be a valid bill type for certain non-Medicare claims. See NUBC requirements for further details.

Most Medicare fee-for-service payer and provider systems will need to change in order to accommodate this change of bill type. All Medicare fee-for-service systems will implement the change of the TOB for FQHCs from 73x to 77x effective for all claims with DOS on or after April 1, 2010.

Effective with dates of service on or after April 1, 2010, Medicare will return to provider (RTP) any FQHC claims submitted on TOB 73x. Such claims will be returned with **group code CO** (contractual obligation) and adjustment **reason code 5** (the procedure code/bill type is inconsistent with the place of service.). If this edit is received, you should resubmit with the 77x bill type.

Additional information

The official instruction, CR 6338, issued to your FI and A MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R477OTN.pdf*.

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

MLN Matters® Number: MM6338
Related Change Request (CR) Number: 6338
Related CR Release Date: April 24, 2009
Related CR Transmittal Number: R477OTN
Effective Date: April 1, 2010
Implementation Date: April 1, 2010

Source: CMS Pub. 100-20, Transmittal 477, CR 6338

April 2009 quarterly provider specific file update

The April 2009 quarterly provider specific files (PSF) statistical analysis software (SAS) data files have been revised and are now available on the Centers for Medicare & Medicaid Services (CMS) Web site in the Downloads section at *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp*.

If you use the provider specific SAS file data, please go to the page above and download the latest version of the PSF files.

Note: These are the quarterly data sets for the provider specific data for public use in SAS format.

The April 2009 quarterly provider specific files (PSF) text data files have been revised and are now available on the CMS Web site at in the *Downloads* section *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp*.

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

Note: These are the quarterly data sets for the provider specific data for public use in text format." ❖

Source: CMS PERL 200905-06

July 2009 quarterly average sales price update and revision to prior files

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

Provider types affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors [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

This article is based on change request (CR) 6471 and instructs Medicare contractors to download and implement the July 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 April 2009, January 2009, October 2008, and July 2008, files. They will use the July 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 July 6, 2009, with dates of service July 1, 2009, through September 30, 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 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, and
- 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), or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

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

Average sales price methodology

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

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

Beginning January 1, 2008, under the outpatient prospective payment system (OPPS), payment allowance limits for specified covered outpatient drugs are paid at ASP plus five percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus 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. There are exceptions to this general rule and they are stated in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 and may be reviewed on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf*.

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.

Use of quarterly payment files

The following table shows how the quarterly payment files will be applied:

July 2009 quarterly average sales price update and revision to prior files (continued)

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2009 ASP and ASP NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
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

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.

Additional information

The official instruction (CR 6471) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1737CP.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*.

MLN Matters® Number: MM6471
Related Change Request (CR) Number: 6471
Related CR Release Date: May 15, 2009
Related CR Transmittal Number: R1737
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1737, CR 6471

Information regarding national claim crossover process

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

Provider types affected

All Medicare physicians, providers, and suppliers.

Provider action needed

Physicians, providers, and suppliers should note that this special edition article is to request that they allow sufficient time for the Medicare crossover process before attempting to balance bill their patients' supplemental insurers and payers for amounts remaining after Medicare's payment determination on their submitted claims.

Background

The Centers for Medicare & Medicaid Services (CMS) consolidated the "automatic" or eligibility file-based crossover process under the coordination of benefits contractor (COBC) as of September 2006. Under the "automatic" crossover process, other supplemental insurers, including Medicaid agencies, sign a standard national Coordination of Benefits Agreement (COBA) with the CMS contractor, the COBC. They then submit enrollment information via a standard eligibility file feed through a secure connection with the COBC. Within this eligibility feed, the supplemental insurers identify their covered members or policy/ certificate holders for Medicare claim matching purposes. The COBC, in turn, transmits this information to the CMS common working file (CWF). After the CMS CWF system tags individual claims for crossover to a designated insurer, it then prompts the Medicare contractor to send the adjudicated claims to the COBC for crossover purposes once the claims have met their payment floor requirements, as prescribed by CMS.

The CMS consolidated the Medigap claim-based crossover process under the COBC in October 2007. Under this process, the COBC assigns to a Medigap plan a five-digit Medigap claim-based COBA ID (range 55000 through 59999) to ensure that if participating Part B physicians or suppliers enter that value on incoming paper CMS-1500 claim forms or 837 professional claims, the Medicare contractor will be able to transfer the claims to the COBC for crossover to that specific Medigap plan.

Important: Virtually all Medigap insurers participate in the automatic or eligibility file-based crossover process. Approximately ten or eleven Medigap plans avail themselves of the less commonly used Medigap claim-based crossover process, which cannot be used in association with Part A 837 institutional claims (including inpatient, outpatient, home health, and hospice related types of bills) or with claims for which the physician or supplier is nonparticipating with Medicare. These insurers, some of whom also participate in part in the automatic crossover process, may be referenced on the CMS Web site at *http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf*.

Information regarding national claim crossover process (continued)

Situations where balance billing of supplemental insurers is justified

Situation 1: Claim data errors encountered

Approximately 98 percent of all claims that Medicare indicates crossed-over, as annotated on its generated 835 electronic remittance advice (ERA) and standard paper remittance advice (SPR), actually were successfully transmitted to supplemental insurers. For the remaining two percent of cases, the physician, provider, or supplier's claims fail Health Insurance Portability and Accountability Act (HIPAA) compliance within the COBC's code validation routine. In addition, due to Medicare's shared claims processing systems problems, Medicare contractors occasionally transmit structurally unusable claims to the COBC. Such claims are rejected back to the Medicare contractor within 24 hours of receipt. Finally, the COBC may, in some instances, successfully transmit claims to various supplemental insurers only to have them rejected due to issues such as national provider identifier (NPI) mismatch (dispute error code 200), claims selection criteria problems (dispute error code 600), and less frequently HIPAA compliance matters (dispute error code 700).

When the COBC rejects claims back to the Medicare contractors, they issue special correspondence letters (sent to your Medicare on-file "correspondence" address) to your organization within five business days from COBC's rejection action. The special letters indicate the affected claims, including health insurance claim number (HICN) and associated internal control number (ICN)/ document control number (DCN), along with an error code and error description specifying why the COBC could not cross-over the affected claims. This same procedure occurs when insurers reject claims, typically several days later through a dispute process with the COBC, with the exception that standard verbiage is carried on the special letter indicating that the affected claim(s) was/were rejected by the supplemental insurer and an associated dispute error code appears (e.g., 200, 600, 700). When providers receive such notifications, they should then attempt to bill the supplemental insurer or benefit program, given that Medicare was unable to cross-over the affected claim(s) successfully.

Situation 2: Patient's insurer not part of crossover process

If you can clearly determine that your patient's insurer cannot or will not voluntarily participate in the CMS national crossover process, you are, of course, within your rights to balance bill your patient's supplemental insurer.

A special note regarding claim repair processes

When a Medicare contractor's volume of HIPAA compliance rejections equals or exceeds four percent of all claims that the affected Medicare contractor transmitted to the COBC for a given day, or if entire envelopes of claims fail structural editing at the COBC, that Medicare contractor is instructed by CMS to go into "claim repair mode." That is, the Medicare contractor is to do the following:

- Determine how long it will take, working through its shared claims processing system maintainer, to effectuate a correction of the errored claims
- Subject to concurrence from CMS, initiate a claim repair for all claims with a given error condition. Typically, most repairs are accomplished within 10 to 15 business days from the date when the COBC rejected the claims.

Important: At CMS direction, most Medicare contractors, including Medicare administrative contractors (MACs), will alert you to such situations in the interests of ensuring that you do not balance bill your affected patients' supplemental insurers or benefit programs. In the majority of instances, Medicare contractors will issue the special correspondence letters, which have been held within the system, if they have determined through consultation with CMS that a claims repair cannot be accomplished. You may also receive additional information about the abandonment of a claims repair process via the affected Medicare contractors' provider Web site.

Requested physician, provider, and supplier action

Recently, CMS has received a growing number of complaints from supplemental insurers about their receipt of paper SPRs or printed 835 ERAs that physician, provider, and supplier billing vendors are generating well in advance of their receipt of the CMS "official" Medicare crossover claims. Consequently, these supplemental insurers are in receipt of duplicate claim pairings—one generated on paper by the provider and another, the "official" crossover claim, generated from the COBC.

Since payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients' supplemental insurers for a minimum of 15 work days after receiving the Medicare payment.

This should allow sufficient time for any potential CMS-approved Medicare claims recovery situations should they need to occur and for the supplemental insurer to take actions necessary to issue payment determination following its receipt of a Medicare crossover claim. Additionally, CMS requests that physicians, providers, and suppliers take the following actions before balance billing their patients' supplemental insurers:

- Check the following CMS Web site for verification that your patient's supplemental insurer is participating in the automatic crossover process nationally with the CMS COBC on the CMS Web site at *http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf*.

  Note: As verified by the spreadsheet's header, this document is a listing of all participants in the Medicare automatic crossover process. It is not just a listing of beneficiary and provider contact information for each insurer indicated.

- Prior to submitting a claim to a supplemental payer/ insurer, you should utilize available self-service tools to research the status of your supplemental payment (e.g., the supplemental insurer's Web site, or claims automated "hot line," as applicable).

In addition, as a reminder, only the "official" Medicare remittance advice or HIPAA 835 ERA should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access

Information regarding national claim crossover process (continued)

Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:

- You are billing the supplemental payer/insurer after the 15 work days from the Medicare-issued payment have expired, and
- You have used the available self-service tools to confirm the status of your supplemental payment.

Additional information

You may also want to review *MLN Matters*® article MM5601 (Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)) on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.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*.

MLN Matters® Number: SE0909
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 SE0904

Modification of the common working file to transmit qualifier WC

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, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services related to workers' compensation liability claims.

Provider action needed

This article is based on change request (CR) 6438 and is informational only for providers. In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), a prior instruction from Medicare, CR 5371, provided your Medicare contractors with instructions on the creation of a new Medicare secondary payer (MSP) code in Medicare's claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) has the capability to discontinue conditional payments for diagnosis codes related to WCMSA settlements.

Background

A 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 qualifier WC denotes a workers' compensation Medicare set-aside arrangement.) CMS has a review process for proposed WCMSA amounts and updates its systems in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit on the CMS Web site *http://www.cms.hhs.gov/WorkersCompAgencyServices*.

CR 5371 added qualifier WC to distinguish a WCMSA Medicare secondary payer (MSP) auxiliary record from a WC MSP record. An *MLN Matters*® article related to CR 5371 is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf*.

Even though qualifier WC was added by CR 5371, no adjustment was made to allow for the transfer of the WC modifier's alpha codes from the CWF system to other important Medicare systems and CR 6438 will implement that transfer.

Additional information

The official instruction, CR 6438, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R487OTN.pdf*.

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

MLN Matters® Number: MM6438
Related Change Request (CR) Number: 6438
Related CR Release Date: May 1, 2009
Related CR Transmittal Number: R470OTN
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-20, Transmittal 487, CR 6438

Update to the list of Medicare telehealth services

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

Provider types affected

Hospitals, provider-based renal dialysis facilities, physicians, and practitioners who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs) for Medicare telehealth services related to end-stage renal disease.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6458, which updates the list of Medicare telehealth services to reflect the coding changes for ESRD-related services that took effect during the 2009 Healthcare Procedural Coding System (HCPCS) update.

Caution – what you need to know

The list of approved telehealth services is updated to reflect the deletion of the ESRD-related G-codes and the addition of the *CPT* codes. The established policy for telehealth services has not changed.

Go – what you need to do

You should use the updated codes and advise your billing staff of the coding changes.

Background

The 2009 HCPCS update added several new *Current Procedural Terminology* (*CPT*) procedure codes related to ESRD services and deleted the related G-codes, effective for dates of service on or after January 1, 2009. A number of these ESRD-related services are on the list of approved telehealth services. The list of approved telehealth services has been updated to reflect the deletion of the G-codes and the addition of the *CPT* codes. The established policy for telehealth services has not changed.

Code changes

- Effective January 1, 2009, carriers and MACs will pay for *CPT* codes *90951*, *90952*, *90954*, *90955*, *90957*, *90958*, *90960*, and *90961* according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GT or GQ.
- Effective January 1, 2009, FIs or MACs will pay for *CPT* codes *90951*, *90952*, *90954*, *90955*, *90957*, *90958*, *90960*, *and 90961* according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GT or GQ by critical access hospitals that have elected method II on type of bill 85x.

Note: Contractors do not have to search their files and reprocess claims for *CPT* codes *90951*, *90952*, *90954*, *90955*, *90957*, *90958*, *90960*, and *90961* with dates of service on or after January 1, 2009, but will adjust any claims for these services that you bring to their attention.

Additional information

For complete details regarding this CR please see the official instruction (CR 6458) issued to your Medicare contractor. That instruction was issued in two transmittals. The transmittal revising the *Medicare Benefit Policy Manual* is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R105BP.pdf*.

The transmittal conveying changes to the *Medicare Claims Processing Manual* is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1716CP.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*.

MLN Matters® Number: MM6458
Related Change Request (CR) Number: 6458
Related CR Release Date: April 24, 2009
Related CR Transmittal Number: R105BP and R1716CP
Effective Date: January 1, 2009
Implementation Date: May 26, 2009

Source: CMS Pub. 100-04, Transmittal 1716, CR 6458

Information on swine influenza

For the most current information about the swine influenza, visit the Centers for Disease Control and Prevention (CDC) Web site at *http://www.cdc.gov/swineflu/*.

At the CDC site, you will find the most current information on consumer and provider fact sheets, guidance for professionals, press briefings, and steps that you, your staff, and patients can take to protect against the infection of the swine flu. ❖

Source: CMS PERL 200904-32

Ensuring only clinical trial services receive fee-for-service payment on claims billed for managed care beneficiaries

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

Provider types affected

Hospitals submitting outpatient claims to Medicare contractors (fiscal intermediaries [FI] and Medicare administrative contractors [MAC]) for outpatient clinical trial services provided to Medicare beneficiaries enrolled in managed care plans are affected.

Provider action needed

This article is based on change request (CR) 6455, which provides additional clarification about billing and processing claims for outpatient clinical trial services to managed care enrollees.

For beneficiaries enrolled in a managed care plan, institutional providers, like hospitals, must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day/stay for a Medicare managed care patient, the provider must **only** bill the clinical trial services to Medicare to be processed as though the services were rendered to a Medicare fee-for-service (FFS) patient. (This allows the Medicare claims processing system to pay for the services on a FFS basis and to not apply deductible when the patient is found to be in a managed care plan.) Any outpatient services unrelated to the clinical trial should be billed to the managed care plan. Hospitals should ensure that their billing staffs are aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) has recognized a need to provide additional clarification about billing and processing clinical trial services. CR 6455 updates Medicare system editing to ensure accurate billing, and ultimately correct pricing of clinical trial services provided to managed care beneficiaries.

Medicare policy is to pay for covered clinical trial services furnished to beneficiaries enrolled in managed care plans. The clinical trial coding requirements for managed care enrollee claims are the same as those for regular Medicare FFS claims. However, for beneficiaries enrolled in a managed care plan, institutional providers must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day/stay, the provider must bill **only** the clinical trial services to Medicare for processing as FFS. (This allows the Medicare claims processing system to not apply deductible when the patient is found to be in a managed care plan.)

Medicare contractors will reject line items that are not related to the clinical trial and, therefore, not payable under FFS for managed care enrollees. Contractors will use the following messages when line-item rejecting:

Medicare Summary Notice:

11.1 – Our records show that you are enrolled in a Medicare health plan. Your provider must bill this service to the plan.

Claim Adjustment Reason Code:

24 – Charges are covered under a capitation agreement/ managed care plan.

Group Code:

CO – Contractual obligation

Additional information

The official instruction, CR 6455, issued to your Medicare FI and/or MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1723CP.pdf*.

If you have questions, please contact your Medicare FI and/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*.

MLN Matters® Number: MM6455
Related Change Request (CR) Number: 6455
Related CR Release Date: May 1, 2009
Related CR Transmittal Number: R1723CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1733

Billing routine costs of clinical trials

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 revised *MLN Matters* article MM6431 to reflect a revision to change request (CR) 6431, with a release date of May 22, 2009. The transmittal number, clarification on the effective date, and the Web address for accessing CR 6431 have changed. All other information is the same. The *MLN Matters* article MM6431 was published in the April 2009 *Medicare A Bulletin* (page 9).

Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare administrative contractors (MACs) and carriers for clinical trials.

Provider action needed

This article is based on change request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. **It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.**

Background

CR 6431 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trails). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the **modifier QV or Q1** is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor **will not** consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed 90 days after issuance of CR 6431 with dates of service on or after January 1, 2008, claims submitted with either the **modifier QV or the modifier Q1** will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:

  Claim adjustment reason code 16 – Claim/service lacks information which is needed for adjudication, **and**

  As least **one remark code,** which may be comprised of either:

  - The remittance advice code (M76, Missing/ incomplete/invalid diagnosis or condition) **or**
  - National council for prescription drug programs reject reason code.

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

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30
- Report a secondary diagnosis code of V70.7, and
- Identify all lines that contain an investigational item/ service with a HCPCS modifier of:
  - **QA/QR** for dates of service before January 1, 2008, or
  - **Q0** for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
  - **QV** for dates of service before January 1, 2008, or
  - **Q1** for dates of service on or after January 1, 2008.

Additional information

The official instruction (CR 6431) issued to your Medicare MAC, or carrier is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1743CP.pdf*.

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

MLN Matters® Number: MM6431 – Revised
Related Change Request (CR) Number: 6431
Related CR Release Date: May 22, 2009
Related CR Transmittal Number: R1743CP
Effective Date: For claims with dates of service on or after January 1, 2008, and processed after July 10, 2009
Implementation Date: July 10, 2009

Source: CMS Pub. 100-04, Transmittal 1721, CR 6431

Clarification on billing of routine foot care when payment ceases for loss of protective sensation evaluation and management

Background

The Centers for Medicare and Medicaid Services (CMS) is clarifying the requirement for podiatric treatment in the Medicare Claims Processing Manual (Publication 100-04, Chapter 32, Section 80.8). This clarification is necessary to support podiatric coverage requirements found in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 290).

Common working file (CWF) utilization edits (Section 80.8)

Edit 1

Should CWF receive a claim from an FI (fiscal intermediary) for G0245 or G0246 and a second claim from a contractor for either G0245 or G0246 (or vice versa) and they are different dates of service and less than six months apart, the second claim will reject. CWF will edit to allow G0245 or G0246 to be paid no more than every six months for a particular beneficiary, regardless of who furnished the service. If G0245 has been paid, regardless of whether it was posted as a facility or professional claim, it must be six months before G0245 can be paid again or G0246 can be paid. If G0246 has been paid, regardless of whether it was posted as a facility or professional claim, it must be six months before G0246 can be paid again or G0245 can be paid. CWF will not impose limits on how many times each code can be paid for a beneficiary as long as there has been six months between each service.

The CWF will return a specific reject code for this edit to the contractors and fiscal intermediaries (FIs) that will be identified in the CWF documentation. Based on the CWF reject code, the contractors and FIs must deny the claims and return the following messages:

MSN 18.4: This service is being denied because it has not been __ months since your last examination of this kind (Note: Insert six as the appropriate number of months.)

RA claim adjustment reason code 96 – noncovered charges, along with remark code M86: Service denied because payment already made for same/similar procedure within set time frame.

Edit 2

The CWF will edit to allow G0247 to pay only if either G0245 or G0246 has been submitted and accepted as payable on the same date of service. CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on this reject code, contractors and FIs will deny the claims and return the following messages:

MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 107: The related or qualifying claim/service was not identified on this claim.

Edit 3

Once a beneficiary's condition has progressed to the point where routine foot care becomes a covered service, payment will no longer be made for LOPS (loss of protective sensation) evaluation and management services. Those services would be considered to be included in the regular exams and treatments afforded to the beneficiary on a routine basis. The physician or provider must then just bill the routine foot care codes, per Pub 100-02, Chapter 15, Section 290.

The CWF will edit to reject LOPS codes G0245, G0246, and/or G0247 when on the beneficiary's record it shows that one of the following routine foot care codes were billed and paid within the prior six months: *11055, 11056, 11057, 11719, 11720*, and/or *11721*.

The CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the contractors and FIs must deny the claims and return the following messages:

MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 96 – noncovered charges, along with remark code M86: Service denied because payment already made for same/similar procedure within set time frame.

Source: CMS Pub. 100-04, Transmittal 1742, CR 6456

Fact sheet to assist with converting International Classification of Disease coding systems

The general equivalence mappings – ICD-9-CM to and from ICD-10-CM and ICD-10-PCS (March 2009) fact sheet, which provides information and resources regarding the general equivalence mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network.* To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200905-03

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

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters special edition* article SE0832 to modify the description of the ICD-10 clinical modification/procedure coding system and to modify a Web address to link to the ICD-10 final rule. All other information is the same. The *MLN Matters* article SE0832 was published in the October 2008 *Medicare A Bulletin* (pages 4-5).

Provider types affected

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

Provider action needed

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

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

Background

The following countries already use ICD-10 coding system:

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

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

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

ICD-10-CM/PCS

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

Structural differences between the two coding systems

1. **Diagnosis codes**

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

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

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

A78	Q fever
A69.21	Meningitis due to Lyme disease
S52.131a	Displaced fracture of neck of right radius, initial encounter for closed fracture.

2. **Procedure codes**

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

43.5	Partial gastrectomy with anastomosis to esophagus
44.42	Suture of duodenal ulcer site.

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

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

0FB03ZX Excision of liver, percutaneous approach, diagnostic

0DQ10ZZ Repair, upper esophagus, open approach.

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

Additional information

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

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

The ICD-10 final rule is available on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf*.

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

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

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

MLN Matters® Number: SE0832 – Revised
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Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE00832

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 percent**, **effective April 16, 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
January 23, 2009 – April 15, 2009	11.375 %
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%. ❖

Source: CMS Pub. 100-06, Transmittal 151 CR 6240

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation

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

Note: CMS has revised *MLN Matters* special edition article SE0903 to provide important information for suppliers who choose not to become accredited. The *MLN Matters* article SE0903 was published in the March 2009 *Medicare A Bulletin* (pages 19-21).

Provider types affected

All suppliers that furnish Medicare Part B durable medical equipment (DME), prosthetic devices, prosthetic or orthotic items, and medical supplies to Medicare beneficiaries.

Provider action needed

Stop – impact to you

DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) suppliers enrolled with the national supplier clearinghouse (NSC) are required to obtain accreditation by **September 30, 2009.**

Caution – what you need to know

In order to obtain or retain a Medicare Part B billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health & Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. These standards may be found in 42 CFR 424.57 or on page 36 and 37 of the CMS 855S. A DMEPOS supplier's Medicare Part B billing privileges will be revoked **on or after October 1, 2009,** if the DMEPOS supplier fails to obtain accreditation unless the DMEPOS supplier submits a voluntary termination to the NSC **by September 30, 2009.**

Go – what you need to do if you choose not to become accredited

For those DMEPOS suppliers who choose not to become accredited at this time, they will need to submit an amended CMS-855S application which reflects their voluntary termination. This will prevent the supplier from being revoked and subsequently barred from the Medicare program, as cited in 42 CFR Section 424.535(c). For pharmacies that choose not to become accredited but wish to remain a DMEPOS supplier in order to continue to bill Medicare for drugs and biologicals only, an amended CMS 855S will have to be completed. In addition to updating their application, the supplier must ensure that they have checked the appropriate boxes in Section 2 (C) to reflect which drugs and biologicals they will provide to beneficiaries. Providers and suppliers can find the latest version of CMS 855S on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf*.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act) that required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to obtain or retain their a provider or supplier billing privileges.

Covered items and services

Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834 (a) (13), Section 1834 (h) (4) and Section 1842 (s) (2) of the Act. The covered items and services include:

- Durable medical equipment (DME)
- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies
- Blood products
- Transfusion medicine
- Prosthetic devices
- Prosthetics, and orthotics.

Noncovered items

- Medical supplies furnished by home health agencies
- Drugs used with DME (inhalation drugs and drugs infused with a DME pump)
- Implantable items
- Other Part B drugs:
  - Immunosuppressive drugs
  - Anti-emetic drugs.

DMEPOS quality standards

The quality standards, published at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf* on the CMS Web site, are separated into two sections and have three appendices as follows:

- **Section I** includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management, product safety and information management.
- **Section II** contains service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service.
- **Appendix A** addresses respiratory equipment, supplies and services.
- **Appendix B** addresses manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation (continued)

- **Appendix C** addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic, ocular and facial prostheses.

Accreditation deadline for DMEPOS suppliers

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) set a deadline for all DMEPOS suppliers to be accreditated **by September 30, 2009**.

Who needs accreditation?

The September 30, 2009, accreditation deadline applies to all suppliers of DME, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics that are enrolled with NSC. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

Who is exempt?

The eligible professionals that are exempt from the September 30, 2009, accreditation deadline include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act)
- Physician assistants
- Nurse practitioners
- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Certified nurse-midwive
- Clinical social workers
- Clinical psychologists
- Registered dietitians, and
- Nutritional professionals.

Additionally MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the September 30, 2009, accreditation deadline unless the Secretary determines that the quality standards are specifically designed to apply to such other persons. At this time, these "other persons" are only defined as the following practitioners:

- Orthotists
- Prosthetists
- Opticians
- Audiologists.

Key points

All Medicare Part B enrolled DMEPOS providers and suppliers are required to obtain accreditation by September 30, 2009.

DMEPOS suppliers who submitted a completed application to an accrediting organization on or before January 31, 2009, **will have their accreditation decision** (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization after January 31, 2009, **may or may not have their accreditation decision** by the September 30, 2009, deadline.

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on or after October 1, 2009, if the DMEPOS supplier fails to obtain accreditation or a voluntary termination has not been received by the NSC by September 30, 2009. **If a supplier chooses not to become accredited, they must submit an amended CMS 855S to prevent revocation and subsequent exclusion from the Medicare program.**

Accreditation frequently asked questions (FAQs)

1. **Do the accrediting organizations have enough capacity to get everyone who applies at least nine months before September 30, 2009 accredited by the deadline?**

   Yes. The AO's have increased surveyor staffing anticipating the additional workload. A DMEPOS supplier should choose an AO based upon their deemed status, policies, procedures and the philosophy of the organization. CMS encourages suppliers to ask the AO's questions, such as, how long it takes to become accredited from application to accreditation decision. The time to become accredited can take up to nine months for some organizations.

2. **Who are the approved DMEPOS accrediting organizations?**

   In November 2006, CMS approved (deemed) 10 national accreditation organizations that will accredit providers and suppliers of DMEPOS as meeting new quality standards under Medicare Part B. Most of the accreditation organizations are authorized to accredit all major supplier types, and most will be able to accredit both national and local suppliers, as well as mail order companies. A list of the CMS-approved deemed accreditation organizations and information about the types of suppliers each accrediting organization is approved to accredit and how to contact a deemed accrediting organization is posted on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf*.

3. **Is accreditation transferable upon merger, acquisition or sale of a supplier?**

   Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57 (c) (3), CMS, the NSC and the accrediting organization must be notified when a new DMEPOS location is opened.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation (continued)

4. **If I have just recently received a survey by an accreditor, will I be subject to a site visit by a representative of the NSC?**

   These actions are independent of one another. The accreditor checks quality standards. The NSC site visit concerns enforcing supplier standards. In many cases a new supplier will receive a site survey by the AO and a site visit by the NSC.

5. **Is information transferred between the accreditor and NSC?**

   Transfer of information between these two entities concerning their findings does occur.

6. **Will the accreditation survey efforts be coordinated with reenrollment efforts?**

   Not at the present time. A supplier must meet both the NSC supplier standards and the accreditation requirements on a continuous basis. We are not changing reenrollment dates and timeframes to match survey timeframes.

Additional information

There is additional information on the accreditation process on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp#TopOfPage*.

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*.

MLN Matters Number: SE0903 – Revised
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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0903

Clarification About the Medical Privacy of Protected Health Information

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 revised *MLN Matters special edition* article SE0726 to reflect updated Web addresses for several products referenced in the article. All other information is the same. The *MLN Matters* article SE0726 was published in the September 2007 *Medicare A Bulletin* (pages 11-12).

Provider types affected

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

Provider action needed

The purpose of this special edition (SE) article, SE0726, is be sure that health care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health & Human Services (HHS) has published to clarify the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the privacy rule protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance

HHS' educational materials include a letter to health care providers with the following examples to clarify the privacy rule:

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) by searching the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found on the HHS Web site at *http://www.hhs.gov/hipaafaq/*.

Clarification About the Medical Privacy of Protected Health Information (continued)

- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is on the HHS Web site at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html*.
- Review the "Summary of the HIPAA Privacy Rule" on the HHS Web site at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html*.

HIPAA does not require providers to eliminate all incidental disclosures:

- The privacy rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that rule to clarify that incidental disclosures do not violate the privacy rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR Web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the fact sheet on "Incidental Disclosures". The fact sheet is on the HHS Web site at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html*.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The privacy rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the provider's guide on communications with a patient's family, etc. on the HHS Web site at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf*.

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" on the HHS Web site at *http://www.hhs.gov/ocr/privacy/hipaa/faq/administrative/485.html*.

HIPAA does not prevent child abuse reporting:

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which may be found, for instance, by searching on the term "child abuse" or review the fact sheet on "Public Health" that may be reviewed on the HHS Web site at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html*.

HIPAA is not anti-electronic:

Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the privacy rule went into effect. A helpful discussion on this topic may be found on the HHS Web site at *http://www.hhs.gov/hipaafaq/providers/smaller/482.html*.

Additional Information

The HHS complete listing of all HIPAA medical privacy resources is available on the HHS Web site at *http://www.hhs.gov/ocr/hipaa/*.

MLN Matters Number: SE0726 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0726

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options Inc. (FCSO), your Medicare administrative 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://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL COVERAGE

Training Medicare patients on use of home glucose monitors and related billing information

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

Provider types affected

Physicians, providers, suppliers, and other healthcare professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for Medicare-covered diabetes self-management training (DSMT) benefits.

Provider action needed

This special edition article is being provided to help clarify the physician's role in prescribing and/or providing blood glucose self-testing equipment and supplies and DSMT-covered for Medicare beneficiaries with diabetes. The article reminds providers and suppliers about who may bill for DSMT and gives an overview of this benefit.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 23.6 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. This special edition article presents an overview of diabetes supplies and self-management training covered by Medicare.

Diabetes self-management training (DSMT)

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of DSMT services when these services are furnished by a certified provider who meets certain quality standards. The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

DSMT services may be covered by Medicare only if the treating physician or treating qualified nonphysician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified nonphysician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician may order less than 10 hours of training)
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training)
- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in a file that includes the original order from the physician and any special conditions noted by the physician. When the training under the order is changed, the training order/referral must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT program records.

Initial training

The initial year for DSMT is the 12-month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109
- DSMT is furnished within a continuous 12-month period
- DSMT does not exceed a total of 10 hours (the 10 hours of training may be done in any combination of one-half hour increments)
- With the exception of one hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries
- The one hour of individual training may be used for any part of the training including insulin training.

Follow-up training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year
- Group training consists of two to 20 individuals who need not all be Medicare beneficiaries
- Follow-up training for subsequent years is based on a 12-month calendar after completion of the full 10 hours of initial training
- Follow-up training is furnished in increments of no less than one-half hour
- The physician (or qualified nonphysician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

Training Medicare patients on use of home glucose monitors and related billing information (continued)

Note: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Certified providers of diabetes self-management training

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to their Medicare contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. CMS has designated all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers as certified. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

Coding and payment of diabetes self-management training services

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used for DSMT:

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Additional Information

For complete details on Medicare policy for DSMT, see the *Medicare Benefits Policy Manual* (Chapter 15, Section 300) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf*.

For detailed billing instructions for DSMT, see the *Medicare Claims Processing Manual* (Chapter 18, Section 120.1 [Coding and Payment of DSMT Services]) at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf*.

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

MLN Matters® Number: SE0905
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 SE0905

July 2009 changes to the laboratory national coverage determination edit software

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 6481, which announces the changes that will be included in the July 2009 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in April 2009. Be sure staff is aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Effective January 1, 2003, nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation.

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

CR 6481 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for July 2009 as described below. These changes become effective for services furnished on or after July 1, 2009 and are as follows:

For prothrombin time (PT)

Add ICD-9-CM codes 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, and 440.4 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

For serum iron studies

Add ICD-9-CM codes 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, and 202.70-202.78 to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.

For lipid testing

Add ICD-9-CM code 440.4 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

For gamma glutamyl transferase

Add ICD-9-CM codes 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78 and 202.70-202.78 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

Additional information

The official instruction (CR 6481) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1735CP.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*.

MLN Matters® Number: MM6481
Related Change Request (CR) Number: 6481
Related CR Release Date: May 15, 2009
Related CR Transmittal Number: R1735
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1735, CR 6481

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site *http://medicare.fcso.com* through the CMS Medicare Coverage Database.

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://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

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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://medicare.fcso.com*.

Additions/Revisions to Existing LCDs

AJ3487 Zoledronic acid – revision to the LCD

LCD ID Number: L29009 (Florida)
LCD ID Number: L29041 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for zoledronic acid was last revised on March 12, 2009. Since that time it has been revised. The Food and Drug Administration (FDA) approved a new indication for zoledronic acid (Reclast®), HCPCS code J3488, on March 13, 2009. The new indication is for the treatment and prevention of glucocorticoid-induced osteoporosis in men and women who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and who are expected to remain on glucocorticoids for at least 12 months.

The "Indications and Limitations of Coverage and/or Medical Necessity," "Utilization Guidelines," "ICD-9 Codes that Support Medical Necessity" and the "Coding Guidelines" attachment have all been revised to allow for coverage of this new indication. When billing for this new indication, providers will be required to bill a dual diagnosis. For HCPCS code J3488, the dual diagnosis requirement is as follows: ICD-9-CM code 733.09 (Osteoporosis, other) and ICD-9-CM code E932.0 (Adrenal cortical steroids) must be billed together.

Effective date

This LCD revision is effective for services provided **on or after March 13, 2009,** for claims processed **on or after June 30, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

Additional Medical Information

C9399/J9999: Plerixafor (MOZOBIL™) – clarification of administration

Plerixafor (MOZOBIL™) is a hematopoietic stem cell mobilizer that was approved by the Food and Drug Administration (FDA) on December 15, 2008. It is indicated in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma. The recommended dosage and administration protocol for MOZOBIL™ is to initiate MOZOBIL™ after the patient has received G-CSF once daily for four days. The dose is selected based on 0.24mg/kg actual body weight and is administered by subcutaneous injection approximately 11 hours prior to apheresis. MOZOBIL™ may be repeated up to four (4) consecutive days. Appropriate ICD-9-CM codes for MOZOBIL™ are 202.70-202.78, 202.80-202.88, 202.90-202.98, 203.00 and 203.01.

At this time, the only G-CSF that First Coast Service Options Inc. (FCSO) recognizes as medically reasonable and necessary to be used in combination with MOZOBIL™ therapy is filgrastim (Neupogen®), HCPCS code J1440 or J1441. The G-CSF would be administered via subcutaneous bolus or continuous infusion once daily in the morning for 4 days prior to the first evening dose of MOZOBIL™. FCSO would not expect to see any chemotherapy drugs billed on the same day that Neupogen® is being administered for this course of therapy. In addition, all coverage requirements for Neupogen® outlined in the local coverage determination (LCD) for Neupogen® would still apply, including indications and limitations of coverage, ICD-9-CM codes that support medical necessity, utilization guidelines and documentation guidelines. The LCD for Neupogen® is available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

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Billing for drugs usually administered orally

According to Publication 100-02, the *Medicare Benefit Policy Manual*, Chapter 15 – Covered Medical and Other Health Services, Section 50 – Drugs and Biologicals, the Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see Section 50.1)
- They are of the type that are not usually self-administered (see Section 50.2)
- They meet all the general requirements for coverage of items as incident to a physician's services (see Sections 50.1 and 50.3)
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see Section 50.4)
- They are not excluded as noncovered immunizations (see Section 50.4.4.2)
- They have not been determined by the Food and Drug Administration (FDA) to be less than effective (see Sections 50.4.4).

In order to meet all the general requirements for coverage under the incident-to provision, an FDA approved drug or biological must:

- Be of a form that is not usually self-administered
- Must be furnished by a physician
- Must be administered by the physician, or by auxiliary personnel employed by the physician and under the physician's personal supervision.

The charge, if any, for the drug or biological must be included in the physician's bill, and the cost of the drug or biological must represent an expense to the physician. The program may pay for the use of an FDA-approved drug or biological, if:

- It was injected on or after the date of the FDA's approval
- It is reasonable and necessary for the individual patient
- All other applicable coverage requirements are met.

Medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration. Medicare Part B does not generally cover drugs that can be self-administered, such as those in pill form, or are used for self-injection. However, First Coast Service Options has received claims for many medications that, in most circumstances, would be considered self-administered oral medications (examples include, but are not limited to, ascorbic acid, Tagamet®, Lopressor®, and Vasotec®, among others). In many instances, these drugs have been billed with unlisted codes such as HCPCS code J3490, which requires that this contractor review the claim for medical necessity and manually price the drug.

Contractors will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient's condition, as well as to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form. Contractors will supplement these instructions as necessary, concerning appropriate use of specific injections in other situations. They will use these instructions to screen out questionable cases for special review, further development, or denial when the injection billed would not be reasonable and necessary. If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these instructions, the contractor excludes the entire charge (i.e., for both the drug and its administration). In addition, contractors exclude from payment any charges for other services (such as office visits), which were primarily for the purpose of administering a noncovered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury). Contractors must provide notice 45 days prior to the date that these drugs will not be covered, and this article serves as that notice. During the 45-day time period, contractors will maintain existing medical review and payment procedures. After the 45-day notice, contractors may deny payment for the drugs subject to the notice. ❖

Physician's order for clinical laboratory services and diagnostic procedures

First Coast Service Options Inc. (FCSO) continues to see a large number of errors identified by the comprehensive error rate testing (CERT) contractor for clinical laboratory services and diagnostic procedures. The errors are largely due to the absence of a physician's order on file or for failure to provide a copy of the order when documentation is requested.

It is inappropriate to bill the Medicare program for clinical laboratory services and diagnostic procedures without a physician's order. Many providers and facilities are being required to refund money to Medicare for not having a copy of the physician's order, or for not providing it when requested.

Medicare guidelines require that supporting documentation for laboratory and diagnostic services must include:

- A copy of the physician's/nonphysician practitioner's order
- Documentation that the test was performed
- Record of the result/report

It is imperative that complete records are submitted for review when requested. Without the appropriate physician's order, there is no way for Medicare or the CERT contractor to verify if a test was ordered or whether the exact test ordered was performed. ❖

HOSPITAL SERVICES

New patient discharge status code 21 to define discharges or transfers to court/law enforcement

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

Provider types affected

Hospitals submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or 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) 6385 which provides implementing instructions for a new patient discharge status code 21, which defines discharges or transfers to court/law enforcement. This includes transfers to incarceration facilities such as jail, prison, or other detention facility.

Background

The Centers for Medicare & Medicaid Services (CMS) has required field locator 17 (Patient discharge status code) on the Uniform Billing Claims Form (UB-04) disposition or discharge status of the beneficiary on the submitted claims.

The National Uniform Billing Committee (NUBC) created a new patient discharge status code 21 to define discharges or transfers to court/law enforcement. Patient discharge status code 21 usage includes transfers to incarceration facilities such as jail, prison or other detention facilities. Medicare systems will accept this code for claims with discharge dates on or after October 1, 2009.

Note that for inpatient prospective payment system (IPPS) hospitals, the post-acute transfer payment policy will not apply to claims that contain patient discharge status code 21.

Additional information

The official instruction, CR 6385, 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/R1718CP.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*.

MLN Matters® Number: MM6385
Related Change Request (CR) Number 6385
Related CR Release Date: April 24, 2009
Related CR Transmittal Number: R1718CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1718, CR 6385

Medicare wage index report

In the fiscal year (FY) 2010 hospital inpatient prospective payment system (IPPS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) discussed that Acumen, LLC's final report addressing wage index issues in section 106(b)(2) of the Medicare division of the Tax Relief and Health Care Act of 2006, is divided into two parts.

The first part, now available on Acumen's Web site, analyzes the strengths and weaknesses of the data sources used to construct the Medicare Payment Advisory Commission (MedPAC) and CMS indexes.

The second part will focus on the methodology for computing the wage index and covers issues including the definition of wage areas and methods of adjusting for differences among neighboring wage areas. The second part is expected to be released after the publication of the FY 2010 final rule. Acumen's Web address is *http://www.acumenllc.com/reports/cms*. ❖

Source: CMS PERL 200905-09

Update fiscal year 2009 inpatient prospective payment system PC PRICER

The inpatient prospective payment system (IPPS) personal computer (PC) PRICER for fiscal year (FY) 2009 required a coding correction and has been updated with the latest April 2009 provider data. To download the latest IPPS PC PRICER, go to *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp* and download the FY 2009.5 version of the PC PRICER, updated May 14, 2009.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200905-17 and PERL 200905-29

Fiscal year 2009 inpatient prospective payment system claims with Medicare severity diagnosis related group 956

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

Provider types affected

Inpatient prospective payment system IPPS hospitals submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]).

Provider action needed

This article is based on change request (CR) 6483 which provides instructions for Medicare contractors to download the revised fiscal year (FY) 2009 IPPS PRICER software and adjust FY 2009 overpaid claims that qualified as a transfer under Medicare severity-diagnosis related group (MS-DRG) 956 and had a discharge date on or after October 1, 2008, and were assigned a transfer PRICER return code of '10'. Be sure billing staff is aware of the potential for adjustments of your claims.

Background

FY 2009 IPPS final rule (see Table 5 on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/List.asp*) designated MS-DRG 956 (limb reattachment, hip & femur proc for multiple significant trauma) as a post acute care DRG, not as a special-pay DRG.

MS-DRG 956 incorrectly remained on the list of special-pay post acute care transfer MS-DRGs within the FY 2009 IPPS PRICER. FY 2009 claims that qualified as a transfer under MS-DRG 956 were paid under the special-pay method and, therefore, were overpaid.

CR 6483 instructs that once the latest version of FY 2009 IPPS PRICER software is installed on or about April 27, 2009, Medicare contractors will adjust claims that meet the following criteria:

- Have a discharge date on or after October 1, 2008
- Were assigned MS-DRG 956
- Were assigned a transfer PRICER return code 10.

Medicare FIs and MACs will complete these adjustments by August 1, 2009.

Additional information

The official instruction, CR 6483, issued to your FI or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R492OTN.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*.

MLN Matters® Number: MM6483
Related Change Request (CR) Number 6483
Related CR Release Date: May 8, 2009
Related CR Transmittal Number: R492OTN
Effective Date: Discharges on or after October 1, 2008
Implementation Date: April 27, 2009

Source: CMS Pub. 100-20, Transmittal 492, CR 6483

CMS proposes fiscal year 2010 payment and policy updates for inpatient rehabilitation facilities

Proposal would clarify and strengthen patient selection and care requirements

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on April 28, 2009, that would update payment rates and clarify the framework for Medicare patient selection and care in inpatient rehabilitation facilities (IRFs) during fiscal year (FY) 2010. The proposed rule would apply to more than 200 freestanding IRFs and over 1,000 IRF units in acute care hospitals, and would be effective for discharges occurring on or after October 1, 2009.

The proposed rule's patient selection and care provisions are intended to ensure that Medicare beneficiaries who need the intensive rehabilitation services provided in IRFs continue to have access to high quality care. In addition to the proposed rule, CMS is posting draft revisions to the *Medicare Benefit Policy Manual* (MBPM) for public comment. This draft makes conforming changes to the manual based on the proposed rule; it provides detailed policy guidance regarding the selection of patients for admission to IRFs, and the development and implementation of individual treatment plans. The proposals would create a framework that incorporates current best practices in rehabilitative medicine, while promoting more efficient and focused medical review by Medicare's fiscal intermediaries and administrative contractors.

Comments on the draft MBPM revisions should be submitted through a link that is supplied on the CMS Web site, rather than through the *http://www.regulations.gov/search/index.jsp* Web site used for the submission of comments on proposed regulatory language. CMS intends to issue final updated MBPM policies concurrently with the issuance of the final IRF prospective payment system (PPS) rule.

"CMS is proposing updates to the current IRF coverage criteria that would better reflect industry-wide best practices, and improve understanding and consistency of medical necessity guidelines," said CMS Acting Administrator Charlene Frizzera. "The proposed policies were developed by CMS working closely with the National Institutes of Health and medical directors from several fiscal intermediaries, and taking into account input from the rehabilitation community."

CMS proposes fiscal year 2010 payment and policy updates for inpatient rehabilitation facilities (continued)

The proposed revisions would clarify requirements for preadmission screening to determine whether a patient should receive rehabilitation services in an IRF or in another, less-intensive setting, post-admission treatment planning, and ongoing care coordination throughout the inpatient stay. Specifically, CMS is proposing to:

- Update and clarify the IRF admission criteria to specify that the patient should be able and willing to actively participate in an intensive rehabilitation program and should be expected to make measurable improvement in his or her functional capacity or adaptation to impairments.
- Require that IRF services be ordered by a rehabilitation physician with specialized training and experience in rehabilitation services and be coordinated by an interdisciplinary team, including at least a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. The rehabilitation physician would be responsible for making the final decisions regarding the patient's treatment in the IRF.
- Specify that IRFs use qualified personnel to provide required rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services.
- Emphasize the importance of the post-admission evaluation to document the status of the patient after admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin developing an overall plan of care to meet the individual patient's specific needs. The proposed rule would require the overall plan of care to be completed with input from all of the interdisciplinary team members and to be maintained in the patient's medical record.
- Require the interdisciplinary team to meet weekly to review the patient's progress and make any needed modifications to the individualized overall plan of care.

Since 2002, Medicare has paid rehabilitation hospitals and rehabilitation units in acute care hospitals for inpatient stays under the IRF prospective payment system (PPS). Under the IRF PPS, the patient is classified into a case-mix group (CMG) taking into account his or her overall physical and cognitive status. Medicare makes a single payment to the IRF based on the CMG assignment. In rare cases, Medicare will make an additional payment, called an outlier payment, to the facility when the costs of treating an individual patient are much higher than the payment for the CMG.

The payment rates set by the IRF PPS for rehabilitation therapy services are higher than would be paid for services in other settings, such as hospital outpatient departments, skilled nursing facilities, or in the home health setting. This is because these patients have more severe and more complex medical conditions that need more intensive and coordinated rehabilitation services. A major reason for updating the coverage policies is to help IRFs select appropriate patients who need the comprehensive and more costly rehabilitation services furnished in the IRF setting.

To be paid under the IRF PPS, each facility must demonstrate on an annual basis that at least 60 percent of its total patient population had either a principal or secondary diagnosis that falls within one or more of the qualifying conditions designated in the regulations governing IRFs. (This is commonly referred to as "the 60 percent rule." The list of qualifying conditions is attached.) In calculating an IRF's compliance rate to determine the IRF's compliance with the 60 percent rule CMS has historically used a method that extrapolated the compliance rate from Medicare fee-for-service data. It is now clear that the extrapolation method of determining compliance will be more accurate if Medicare Advantage patients are included in these compliance review calculations. Therefore, CMS is proposing to require submission of IRF patient assessment data on Medicare Part C (Medicare Advantage) patients in IRFs.

In other provisions, CMS projects that the payment rate update for IRFs will be 2.4 percent in FY 2010, based on the rehabilitation, psychiatric, and long-term care (RPL) market basket, and that, if finalized as proposed, the market basket update would increase total payments to IRFs in FY 2010 by $140 million. The RPL market basket was developed to measure the rate of inflation for the resources used in treating the specific types of patients served by these facilities. Also, CMS is proposing to set the outlier threshold for FY 2010 at $9,976, the amount estimated to maintain estimated outlier payments equal to 3.0 percent of total estimated payments under the IRF PPS for FY 2010. The change to the outlier threshold would increase overall IRF payments by $10 million. The total increase in IRF payments under this proposed rule is $150 million.

For facility and patient-level adjustments, which would not increase total IRF payments, the proposed rule would:

- Update the CMG relative weights and average length of stay values using FY 2007 data, which reflect recent changes in IRF patient populations resulting from the 60 percent rule and medical review activities.
- Use the pre-reclassified and pre-floor hospital wage data to determine the proposed FY 2010 rates. The FY 2010 IRF PPS wage index values in the proposed rule are based on the final FY 2009 pre-reclassified and pre-floor hospital wage data.
- Update the rural, low-income patient (LIP), and teaching status adjustment factors using the most recent three years of data (FYs 2005 through 2007).

CMS will accept comments on the proposed rule until June 29, 2009, and will address all comments in a final rule to be issued by August 1, 2009.

The proposed rule went on display on April 28, 2009, at the Office of the Federal Register's Public Inspection Desk and will be available under "Special Filings" at *http://www.federalregister.gov/inspection.aspx*.

For more information, including information about how to submit comments on the draft MBPM provisions, please see *http://www.cms.hhs.gov/InpatientRehabFacPPS/02_Spotlight.asp*. ❖

Source: CMS PERL 200904-33

Clarification on use of national drug codes in 837I billing

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

Note: CMS has revised *MLN Matters* article MM6330 to clarify that the effective date is based on date of services. All other information remains the same. The *MLN Matters* article MM6330 was published in the February 2009 *Medicare A Bulletin* (page 19).

Provider types affected

Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], or Medicare administrative contractors (MAC)) for drugs, especially new drugs provided under the outpatient prospective payment system (OPPS).

What you need to know

Change request (CR) 6330, from which this article is taken, specifies how quantities of drugs are to be reported and then processed by Medicare when the national drug codes (NDC) is used for institutional billing. Specifically, it also requires Medicare contractors to accept decimal values for NDC quantities. CR 6330 also adds to prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA). Be sure your billing staff is aware of these changes.

Background

As provided by CR 3287 issued May 28, 2004, (MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code); Medicare hospitals, subject to the OPPS, may use HCPCS code C9399 to report drugs that have been approved by the FDA, but that do not yet have a product-specific drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective for claims with dates of service on or after July 1, 2009, hospitals billing for drugs/biologicals that have received FDA approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the **quantity** of that drug/biological using the CTP segment in the ANSI X-12 837 I (in loop 2410 LIN 03).

In addition, CR 6330 provides that the use of the 'units field,' while adequate to define quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identified only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity field, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claims processing).

Additional information

For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which may be found by going to the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf*.

You might also want to review the *MLN Matters* article related to CR 3287, which you may find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.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*.

MLN Matters® Number: MM6330 – Revised
Related Change Request (CR) Number: 6330
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R446OTN
Effective Date: July1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-20, Transmittal 446, CR 6330

Inpatient rehabilitation facility prospective payment system PC PRICER update

The April 2009 provider specific data for the fiscal year 2009 inpatient rehabilitation facility prospective payment system (IRF PPS) personal computer (PC) PRICER has been updated and is ready to be downloaded from the page, *http://www.cms.hhs.gov/PCPricer/06_IRF.asp*, under the *Downloads* section.

If you use the IRF PPS PC PRICER, please go to the page above and download the latest version of the IRF PC PRICER, posted on May 14, 2009. ❖

Source: CMS PERL 200905-21

Update fiscal year 2009 inpatient psychiatric facility prospective payment system PC PRICER

The April provider data for the inpatient psychiatric facility prospective payment system (IPF PPS) personal computer (PC) PRICER for fiscal year (FY) 2009 has been updated. If you use the IPF PPS PC PRICER 2009.A and 2009.4, the latest versions (posted May 15, 2009) of the IPF PPS PC PRICER are available at *http://www.cms.hhs.gov/PCPricer/09_inppsy.asp* under the Downloads section.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200905-26

CRITICAL ACCESS HOSPITAL SERVICES

Section 148 of The Medicare Improvements for Patients and Providers Act

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

Provider types affected

Critical access hospitals (CAHs) that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries. Rural health clinics (RHCs), federally qualified health clinics (FQHCs), and skilled nursing facilities (SNFs) may also want to review this article, which clarifies information regarding payment to these entities for laboratory tests performed at an RHC, an FQHC, or a SNF.

What you need to know

Change request (CR) 6395, from which this article is taken, announces a change in the payment methodology for CAHs submitting claims for certain outpatient clinical diagnostic laboratory tests.

As mandated by Section 148 of the Medicare Improvements for Patients and Providers Act (MIPPA), effective for services furnished on or after July 1, 2009, a CAH will be paid 101 percent of reasonable cost for outpatient clinical diagnostic laboratory tests even if the patient for whom these services are billed was not physically present in the CAH at the time the specimen is collected. In such cases, the CAH will receive 101 percent of reasonable cost for the outpatient clinical diagnostic laboratory test as long as the patient is an outpatient of the CAH and is receiving services directly from the CAH. For purposes of section 148, the patient is considered to be receiving services directly from the CAH if either one of the following qualifications is met:

1) The patient receives outpatient services in the CAH on the same day the specimen is collected, or

2) The specimen is collected by an employee of the CAH.

If the patient is physically present in the CAH or a facility that is provider based to the CAH at the time the specimen is collected, neither of the above two conditions need to be met.

For purposes of payment when a patient is located in a SNF and the CAH employee goes to the SNF to collect a specimen, the CAH will only receive payment at 101 percent of reasonable cost once the patient's Medicare Part A days have expired. Prior to the patient's Part A days expiring, payment for the collection of a lab specimen at an SNF is included in the SNF bundled payment.

For non-patients, tests are still to be billed on the type of bill (TOB) 14x and such claims will be paid based on the clinical laboratory fee schedule.

You should make sure that your billing staffs are aware of these changes.

Background

CR 3835 (Redefined Type of Bill (TOB), 14x, for Non-Patient Laboratory Specimens, issued on October 28, 2005), introduced a new definition of type of bill (TOB) 14x, to be used only for non-patient laboratory specimens, effective October 1, 2004; and also provided that CAHs billing a TOB 14x for a non-patient laboratory specimen would be reimbursed under the clinical laboratory fee schedule. (You may find the *MLN Matters*® article related to this CR on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3835.pdf*).

Tests for non-patients are still to be billed on the TOB 14x and such claims will be paid based on the clinical laboratory fee schedule.

However, CR 6395, from which this article is taken, changes the policy of who is considered an outpatient of a CAH when outpatient clinical diagnostic laboratory services are provided, effective for dates of service on or after July 1, 2009. Section 148 of MIPPA provides that the patient for whom the services are provided is no longer required to be physically present in the CAH at the time the specimen is collected; but must be an outpatient of the CAH (as defined by 42 CFR 410.2) as previously noted. If said outpatient requirements are met, a CAH may submit a TOB 85x for outpatient clinical diagnostic laboratory tests for such patients for dates of service **on or after July 1, 2009.** Such services will be paid at 101 percent of reasonable cost.

Note that beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

Please be aware that payment to a rural health clinic (RHC)/federally qualified health clinic (FQHC) for laboratory tests performed for a patient of that clinic/center is not included in the all-inclusive rate and may be billed separately by either the base provider for a provider-based RHC/FQHC, or by the physician for an independent or free-standing RHC/FQHC. If the RHC/FQHC is provider-based, payment for laboratory tests is to the base provider (i.e., hospital). If the RHC/FQHC is independent or freestanding, payment for laboratory tests is made to the practitioner (physician) via the clinical laboratory fee schedule.

Section 148 of The Medicare Improvements for Patients and Providers Act (continued)

Additional information

You may view CR 6395, the official instruction issued to your FI or MAC, on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1729CP.pdf*.

The updated *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Chapter 13 (Radiology Services and Other Diagnostic Procedures), and Chapter 16 (Laboratory Services), are included as an attachment to CR 6395.

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*.

MLN Matters® Number: MM6395
Related Change Request (CR) Number 6395
Related CR Release Date: May 8, 2009
Related CR Transmittal Number: R1729CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1729, CR 6395

ESRD Services

End-stage renal disease frequency of dialysis

First Coast Service Options Inc. (FCSO) has identified a substantial increase in the number of end-stage renal disease (ESRD) claims for monthly dialysis services that exceed the weekly number of treatments allowed under the Medicare benefit. According to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manuals, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 11, Section 30, the Medicare benefit for hemodialysis and peritoneal dialysis include routine coverage of three treatments per week. Additional treatments may be covered when there is medical justification (medically reasonable and necessary).

As a Medicare administrative contractor, FCSO has determined that there are very limited circumstances in which additional dialysis treatments are justified. There are certain conditions that may have acute onsets that may justify the need for additional sessions. As a result, **beginning May 1, 2009, FCSO will modify its process for verifying medical justification of claims billed requesting reimbursement for additional weekly treatments.**

Providers that submit a claim for a total of 15-17 monthly treatments must provide a brief description in form locator 80 of the UB-04 form (or the equivalent for electronic submissions) to provide medical justification for each additional treatment (beyond three weekly). All comments will be reviewed for medical necessity. If no justification is given, additional treatments will be denied.

Providers billing 18 or more total monthly treatments will receive a request for documentation for all services billed on the claim. If documentation is not received within the specified time frame, the claim will be denied. It is expected that the patient's medical records will include documentation that supports additional dialysis treatments.

Reminder: SRD providers are required to submit one monthly claim containing all services provided during that period (e.g., April 1-30). Multiple claims for one month services or claims submitted that span over two months are inappropriate billing of dialysis treatments. ❖

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SKILLED NURSING FACILITY SERVICES

CMS proposes more accurate payment rates for skilled nursing facilities

Case-mix adjustment recalibration proposed

The Centers for Medicare & Medicaid Services (CMS) has proposed adjustments to fiscal year (FY) 2010 payment rates to better reflect the cost of caring for Medicare beneficiaries in nursing homes.

The rule calls for payments to Medicare skilled nursing facilities (SNFs) to be reduced by $390 million, or 1.2 percent lower than payments for FY 2009. This adjustment to nursing facility payments is an effort to rebalance an earlier adjustment to the case-mix indexes (CMIs).

The proposed FY 2010 recalibration of the CMIs would result in a reduction in payments to nursing homes of $1.050 billion, or 3.3 percent. However, this decrease would be largely offset by the proposed update to Medicare payments to SNFs for this fiscal year. The update -- a proposed increase of 2.1 percent or $660 million for FY 2010 – is based on the change in prices of a "market basket" of goods and services included in covered SNF stays. The percentage increase in the market basket is used to compute the update factor annually. The combination of the market basket increase and the recalibration of the CMIs yields the 1.2 percent reduction.

To view the entire press release, please visit the CMS Web site at *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200905-02

Draft minimum data set 3.0 data specifications and data item set

A draft version of the minimum data set (MDS) 3.0 item set has been posted. It may be accessed a *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*. The final version is still scheduled for publication in October 2009.

Note: This is a draft version of the item set and should not be used for training purposes. The final version of the item set, data specifications, and resident assessment instrument (RAI) manual are scheduled for publication in October 2009 on the MDS 3.0 Web page (*http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*)**.**

As additional information becomes available, it will be posted on the MDS 3.0 section of the Centers for Medicare & Medicaid Services (CMS) Web site (see link above) and announced during calls, such as the skilled nursing facilities (SNF)/ long-term care (LTC) open door forum.

For more information about the SNF/LTC open door forum, go to *http://www.cms.hhs.gov/OpenDoorForums/25_ODF_SNFLTC.asp*.

Questions regarding the draft item set should be directed to mailto:20MDS30Comments@cms.hhs.gov. ❖

Source: CMS PERL 200905-18

Update fiscal year 2009 skilled nursing facility prospective payment system PC PRICER

The fiscal year (FY) 2009.0 skilled nursing facilities (SNF) prospective payment system personal computer (PPS PC) PRICER has been updated with the latest April 2009 provider specific file (PSF) data. To download the latest FY 2009.0 version of the PC PRICER file (updated May 14, 2009), go to the Skilled Nursing Facility (SNF PPS) PC PRICER Web page (*http://www.cms.hhs.gov/PCPricer/04_SNF.asp*), under the Downloads section.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200905-27

Revised swing bed fact sheet

The swing bed fact sheet (revised April 2009), which provides information about the requirements hospitals and critical access hospitals must meet in order to enter into a swing bed agreement under which they can use beds, as needed, to provide either acute or skilled nursing facility care, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/SwingBedFactsheet.pdf*. ❖

Source: CMS PERL 200905-20

Medicare Claims Processing Manual clarifications for skilled nursing facility and therapy billing

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

Provider types affected

Skilled nursing facilities and other providers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or 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) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for skilled nursing facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new *Current Procedural Terminology* (*CPT*) code *95992* (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver, per Day*) is bundled under the Medicare physician fee schedule (MPFS).

Regardless of whether *CPT* code *95992* is billed alone or in conjunction with another therapy code, separate Medicare payment is never made for this code. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is included in the allowance for another service/procedure."). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

In addition, CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual* (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that both full and partial benefits exhaust claims must be submitted by SNFs monthly. For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim; and
2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

Note: Part B 22x (SNF inpatient part B) bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a noncovered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a noncovered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

Note: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 (SNF no-payment bill type).

Additional information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1733CP.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*.

MLN Matters® Number: MM6407
Related Change Request (CR) Number: 6407
Related CR Release Date: May 8, 2009
Related CR Transmittal Number: R1733CP
Effective Date: October 1, 2006
Implementation Date: April 27, 2009

Source: CMS Pub. 100-04, Transmittal 1733, CR 6407

May news on five-star quality rating system

The five-star provider preview reports are now available. Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of minimum data set data.

Provider preview access information

Visit the MDS state welcome page (available on the state servers where you submit MDS data) to review your results.

To access the five-star provider preview reports, select the "Certification and Survey Provider Enhanced Reports" (CASPER) reporting link (located at the bottom of the login page). Once in the CASPER reporting system, click on the "Folders" button and access the five-star report in your "st LTC facid" folder."

Note: "st" is the two-digit postal code of the state in which your facility is located, and "facid" refers to the state-assigned facility identifier for your facility.

BetterCare@cms.hhs.gov is available to address May's data concerns and/or issues. The helpline will reopen in July to coincide with quarterly quality measure (QM) data updates. *Nursing Home Compare* was updated with May's five-star data on Thursday, May 28, 2009. ❖

Source: CMS PERL 200905-31

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RURAL HEALTH SERVICES

Rural health clinic and federally qualified health clinic coverage and billing updates

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

Provider types affected

All rural health clinics (RHCs) and federally qualified health clinics (FQHCs) submitting claims and cost reports to Medicare contractors (fiscal intermediaries [FI], and Medicare administrative contractors [MAC]) for services and supplies provided to Medicare beneficiaries.

Provider action needed

This article describes change request (CR) 6445, which updates billing and cost reporting for the following preventive benefits and vaccines provided by RHCs and FQHCs with various effective dates:

- Initial preventive physician examination (IPPE)
- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Individual services for diabetes self-management training (DSMT) services
- Individual services for medical nutrition therapy services (MNT)
- Certain vaccines.

Ensure that your billing and cost reporting staffs are aware of these updates.

Background

For RHCs and FQHCs, professional components of preventive services are part of the overall encounter, and, for types of bill (TOBs) 71x and 73x, have always been billed on lines with the appropriate site of service revenue code in the 052x series. As of April 1, 2005, RHCs and FQHCs were only required to report Healthcare Common Procedure Coding System (HCPCS) codes for a few services. The number of RHC and FQHC services requiring HCPCS coding is increasing for the following reasons: the number of new benefits subject to frequency limits is increasing; for certain preventive benefits, no deductible is applicable on RHC services (all FQHC services are already exempt from application of the deductible.); and the number of circumstances when a provider is eligible to receive payments in addition to the all-inclusive daily encounter rate has increased.

Payment for professional services that meet all of the program requirements is made under the all-inclusive rate. The IPPE and the ultrasound screening for AAA are once in a lifetime benefits. Therefore, HCPCS coding is required to adhere to the statutory limit; to allow for the deductible to be waived when computing payment to RHCs for DOS on or after the effective dates (Note: Deductible is never applied for FQHC services); and, in rare circumstances, depending on the clinical appropriateness of a separate visit, to allow RHCs and FQHCs to receive separate payment for an encounter, in addition to the payment for IPPE or AAA encounter, when they are performed on the same day.

Medicare contractors will not search for and adjust claims already processed, but will adjust claims that you bring to their attention.

Policy clarifications for initial preventive physician examinations

Effective for dates of service (DOS) on or after January 1, 2009, RHCs and FQHCs may bill for the professional portion of an IPPE in addition to a daily encounter by using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series, and must include HCPCS G0402.

For RHCs, the Part B deductible for the IPPE is waived for DOS on or after January 1, 2009. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

Note: The technical component of an electrocardiogram (EKG) performed at a clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the independent RHC or FQHC. Rather, it is billed to Medicare carriers or Part B MACs on professional claims (Form CMS 1500 or 837P) under the practitioner's national provider identifier (NPI) following instructions for submitting practitioner claims. The technical component of the EKG performed at a provider-based clinic/center is not a Medicare covered RHC/FQHC service and is not billed by the provider-based RHC or FQHC. Instead, it is billed on the applicable TOB and submitted to the FI or Part A MAC using the base provider's NPI following instructions for submitting claims to the FI/PART A MAC from the base provider.

Policy clarifications for ultrasound screening for abdominal aortic aneurysm

Effective for DOS on or after January 1, 2007, RHCs and FQHCs need not apply the Part B deductible when billing for ultrasound screening for AAA using the HCPCS code G0389. The professional portion of the service is billed to the FI or PART A MAC using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series and must include HCPCS G0389. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or Part B MAC under the practitioner's NPI following instructions for submitting practitioner claims.

Rural health clinic and federally qualified health clinic coverage and billing updates (continued)

If the screening is provided in a provider-based RHC or FQHC, the technical component of the service can be billed by the base provider to the FI or Part A MAC under the base provider's NPI, following instructions for submitting claims to the FI/Part A MAC from the base provider.

Policy clarifications for DSMT and MNT services

Effective for DOS on or after January 1, 2006, FQHCs may not bill for group services for DSMT or MNT services as a separate qualifying encounter. Group services do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate.

Claims for DSMT group services with HCPCS code G0109 and MNT group services with CPT codes 97804 or G0271 will be denied using group code CO and claim adjustment reason code B5 (Program coverage guidelines were not met or exceeded).

FQHCs may bill for DSMT and MNT services when they are provided in a one-on-one face-to-face encounter and billed using the appropriate HCPCS and site of service revenue codes.

- To receive payment for DSMT services, the DSMT services must be billed on TOB 73x with HCPCS code G0108 and the appropriate site of service revenue code in the 052x revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service that the beneficiary received qualifying DSMT services as long as the claim for DSMT services contains the appropriate coding specified above.
- To receive payment for MNT services, the MNT services must be billed on TOB 73x and with the appropriate site of service revenue code in the 052x revenue code series and the appropriate *CPT/HCPCS* code *(97802, 97803*, or G0270). This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services as long as the claim for MNT services contains the appropriate coding specified above.

Separate payment to RHCs for these practitioners and services continues to be precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note that the provision of these services by registered dietitians or nutritional professionals might be considered incident to services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

Policy Clarifications for Vaccines

RHCs and FQHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x/73x claims. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. CR 6445 clarifies that neither co-insurance nor deductible apply to either of these vaccines.

Hepatitis vaccine is included in the encounter rate. No line items specifically for this service are billed on RHC or FQHC claims. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. Both co-insurance and deductible apply to this benefit. An encounter cannot be billed if vaccine administration is the only service the RHC or FQHC provides.

Additional information

The official instruction (CR 6445) issued to your Medicare MAC and/or FI is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1719CP.pdf*.

The revised portions of the *Medicare Claims Processing Manual* are included in CR 6445.

If you have questions, please contact your Medicare 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*.

MLN Matters® Number: MM6445
Related Change Request (CR) Number: 6445
Related CR Release Date: April 24, 2009
Related CR Transmittal Number: R1719CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1719, CR 6445

Revised rural health clinic fact sheet

The revised rural health clinic fact sheet (April 2009), which provides information about rural health clinic (RHC) services, Medicare certification as an RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralHlthClinfctsht.pdf*. If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200905-13

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

July 2009 integrated outpatient code editor specifications version 10.2

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6480, which notifies providers that the integrated outpatient code editor (I/OCE) specifications version 10.2, is **effective July 1, 2009.** Be sure billing staffs are aware of these changes.

Background

CR 6480 informs Medicare contractors and providers that the I/OCE will be updated for July 1, 2009. CR 6480 provides the integrated OCE instructions and specifications for the I/OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness. A summary of the changes for July 2009 is within Appendix M of Attachment A of CR 6480 and that summary is captured in the following key points.

Key points of change request 6480

Medicare has made the following Healthcare Common Procedure Coding System/ambulatory payment classification/status indicator (HCPCS/APC/SI) changes:

Added ambulatory payment classifications

The following APCs with status indicators (SI) = K have been added effective July 1, 2009:

APC 01268 (Xyntha, inj)

APC 01269 (Alloskin skin sub)

APC 01270 (Alloderm skin sub)

The following APCs with SIs = G have been added effective July 1, 2009.

APC 09250 (Artiss fibrin sealant)

APC 09251 (Inj, C1 esterase inhibitor)

APC 09252 (Injection, plerixafor)

APC 09253 (Injection, temozolomide)

APC 09360 (SurgiMend, neonatal)

APC 09361(NeuraMend nerve wrap)

APC 09362 (Implnt,bone void filler-strip)

APC 09363(Integra Meshed Bil Wound Mat)

APC 09364 (Porcine implant, Permacol)

Ambulatory payment classification description changes

APC 09358 previously had a description of SurgiMend, 0.5cm2 and now has a new description of SurgiMend, fetal.

APC 09359 previously had a description of implant, bone void filler and now has a new description of implnt,bone void filler-putty.

New Healthcare Common Procedure Coding System

All new HCPCS under this heading have an effective date of July 1, 2009.

CPT code *0199T* (Physiologic tremor record), with an APC of 00215 and an SI = S.

CPT code *0200T* (Perq sacral augmt unilat inj), with an APC of 00049 and an SI = T.

CPT code *0201T* (Perq sacral augmt bilat inj), with an APC of 00050 and an SI = T.

CPT code *0202T* (Post vert arthrplst 1 lumbar), with an APC of 00000 and an SI = C.

CPT code *90670* (Pneumococcal vacc, 13 val im), with an APC of 00000 and an SI = E.

HCPCS code C9250 (Artiss fibrin sealant), with an APC of 09250 and an SI = G.

HCPCS code C9251 (Inj, C1 esterase inhibitor), with an APC of 09251 and an SI = G.

HCPCS code C9252 (Injection, plerixafor), with an APC of 09252 and an SI = G.

HCPCS code C9253 (Injection, temozolomide), with an APC of 09253 and an SI = G.

HCPCS code C9360 (SurgiMend, neonatal), with an APC of 09360 and an SI = G.

HCPCS code C9361 (NeuraMend nerve wrap), with an APC of 09361 and an SI = G.

HCPCS code C9362 (Implnt,bon void filler-strip), with an APC of 09362 and an SI = G.

HCPCS code C9363 (Integra Meshed Bil Wound Mat), with an APC of 09363 and an SI = G.

HCPCS code C9364 (Porcine implant, Permacol), with an APC of 09364 and an SI = G.

HCPCS code Q2023 (Xyntha, inj), with an APC of 01268 and an SI = K.

HCPCS code Q4115 (Alloskin skin sub), with an APC of 01269 and an SI = K.

HCPCS code Q4116 (Alloderm skin sub), with an APC of 01270 and an SI = K.

July 2009 integrated outpatient code editor specifications version 10.2 (continued)

HCPCS description changes

HCPCS code C9358 had an old description of SurgiMend, 0.5cm2 and now has a new description of SurgiMend, fetal effective July 1, 2008.

HCPCS code C9359 had an old description of Implant, bone void filler and now has a new description of Implnt,bon void filler-putty effective October 1, 2008.

HCPCS 4266F had an old description of No wet-dry drssings Rx-recmd and now has a new description of No Wet-dry drssings Rx-recmd effective July 1, 2009.

HCPCS changes to edit and/or status indicator

CPT codes *99251*, *99252*, *99253*, *99254* and *99255* were changed from SI = M to SI = C effective January 1, 2009.

HCPCS code K0740 was changed from SI = Y to SI = E and from old edit = 61 to new edit = 9 effective April 1, 2009.

Modifier additions

Modifiers PA, PB and PC are valid modifiers effective January 1, 2009.

Modifiers PI and PS are valid modifiers effective April 1, 2009.

Deleted modifier

Modifier K8 has been deleted from the list of valid modifiers effective April 1, 2009.

Correct coding

Version 15.1 of the national correct coding initiatives will be implemented effective with the July 2009 version of the I/OCE.

Additional information

The official instruction (CR 6480) issued to your Medicare MAC and/or FI is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1739CP.pdf*.

If you have questions, please contact your Medicare 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*.

MLN Matters® Number: MM6480
Related Change Request (CR) Number: 6480
Related CR Release Date: May 15, 2009
Related CR Transmittal Number: R1739CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1739, CR 6480

Note to integrated outpatient code editor users

The October 2009 integrated outpatient code editor (IOCE) version 10.3 will contain several structural changes:

1. The software will be modified to retain 28 quarters (seven years) of programs and codes in each release. The earliest version date included in the October 2009 release will be January 1, 2003. Going forward, the earliest start date will roll each quarter so that each release will conform to include only 28 quarters. If you need to access releases prior to seven years, you will need to maintain a copy of the July 2009 IOCE in your system.
2. The tool set used to generate the basic assembler language (BAL) for the mainframe (MF) IOCE program will be updated. Though minor, the tool set change will slightly change the structure and source code of the mainframe IOCE, resulting in small changes in the procedure for installing the MF IOCE; complete instructions will be included in the MF installation manual.

More information on both of these changes is described in change request (CR) 6401 (*http://www.cms.hhs.gov/transmittals/downloads/R482OTN.pdf*) and CR 6390 (*http://www.cms.hhs.gov/Transmittals/Downloads/R484OTN.pdf*).

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200905-32

The outpatient code editor Web-based training module revised in April 2009

The Centers for Medicare & Medicaid Services has revised the outpatient code editor (OCE) Web-based training (WBT) module in April 2009. This WBT module addresses the OCE in the fiscal intermediary standard system (FISS). It may be accessed by going to *http://www.cms.hhs.gov/MLNGenInfo/*.

Scroll to the "Related Links Inside CMS" section, and select "Web Based Training (WBT) Modules." Then, select the outpatient code editor WBT from the list provided. ❖

Source: CMS PERL 200905-01

ELECTRONIC DATA INTERCHANGE

An introductory overview of HIPAA 5010

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 bill Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

What you need to know

Stop – impact to you

The implementation of Health Insurance Portability & Accountability Act (HIPAA) 5010 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation will require changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you are aware of these HIPAA changes and plan for their implementation.

Caution – what you need to know

The Administrative Simplification Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 version 5010 and NCPDP version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. The Centers for Medicare & Medicaid Services (CMS) will provide additional information to assist you and keep you apprised of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. Remember that the HIPAA standards, including the X12 version 5010 and version D.0 standards, are national standards and apply to your transactions with all payers, not just with Medicare fee-for-service (FFS). Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare expects to begin transitioning to the new formats January 1, 2011, and ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate *MLN Matters*® articles will address the ICD-10 implementation.

Go – what you need to do

In preparing for the implementation of these new X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

HIPAA requires the Secretary of the Department of Health & Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others. The transactions and code sets final rule published on Aug. 17, 2000, adopted standards for the statutorily identified transactions, some of which were modified in a subsequent final rule published on Feb. 20, 2003.

These current versions of the standards (the Accredited Standards Committee X12 version 4010/4010A1 for health care transactions, and the NCPDP version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. On January 16, 2009, HHS announced a final rule that replaces the current version 4010/4010A and NCPDP version 5.1 with version 5010 and version D.0, respectively.

Over 99 percent of Medicare Part A claims and over 95 percent of Medicare Part B claims transactions are received electronically and it is imperative that providers be ready for these new standards in order to continue submitting claims electronically. The remainder of this article will provide some rationale for the new standards and also provide some guidance to providers on preparing for this implementation.

Version 5010 (health care transactions)

Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments). Further, the new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Finally, version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were "present on admission," and accommodating the use of the ICD-10 code sets, which are not supported by version 4010/4010A1.

An introductory overview of the HIPAA 5010 (continued)

Version D.0 (pharmacy claims)

Version D.0 specifically addresses business needs that have evolved with the implementation of the Medicare prescription drug benefit (Part D) as well as changes within the health care industry. New data elements and rejection codes in version D.0 will facilitate both coordination of benefits claim processing and Medicare Part D claim processing.

In addition, version D.0:

- Provides more complete eligibility information for Medicare Part D and other insurance coverage
- Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs.

The 5010/D.0 rule also adopts a standard for the Medicaid pharmacy subrogation transaction(known as NCPDP version 3.0), as currently one does not exist for this process by which state Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility. Since many states presently conduct this transaction electronically, and employ a variety of standards with different payers, adoption of a standard for this transaction will increase efficiencies and reduce costs for Medicaid programs.

The compliance date for implementing version 5010 and version D.0 is January 1, 2012, to allow time to test the standards internally, to ensure that systems have been appropriately updated, and then to transition to the new formats between trading partners before the compliance date. For the Medicaid pharmacy subrogation standard, the compliance date is also January 1, 2012, except for small health plans, which must be compliant on January 1, 2013.

CMS progress in implementing the new standards

CMS is well into the process of readying its Medicare FFS systems to handle the 5010/D.0 standards. All Medicare systems will be ready to handle the new standards by January 1, 2011. Medicare plans for its systems to handle the current 4010A standard and the new 5010/D.0 standards for incoming claims and inquiries and for outgoing replies and remittances from January 1, 2011, until January 1, 2012. This will allow providers who are ready to begin using the new standards on January 1, 2011, while providing an additional year for all providers to be ready.

In addition, where possible, CMS will be making system enhancements concurrent with the 5010/D.0 changes. These enhancements include capabilities such as:

- Implementing standard acknowledgement and rejection transactions across all jurisdictions (TA1, 999 and 277CA transactions)
- Improving claims receipt, control, and balancing procedures
- Increasing consistency of claims editing and error handling
- Returning claims needing correction earlier in the process
- Assigning claim numbers closer to the time of receipt.

Additional information

You may find more information about HIPAA 5010 by going to *http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the Electronic Billing & EDI Transactions page on the CMS Web site. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (version 4010/4010A1) with version 5010 and the NCPDP EDI standards version 5.1 to D.0, and has made these side-by-side comparisons available at this Web site. These comparisons may be of interest to other covered entities and their business associates.

A special edition *MLN Matters*® article on the ICD-10 code set is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf*.

CMS will also use the open door forums and electronic mail lists as means of keeping providers informed of its implementation progress and will also use the vehicles to assist providers in getting ready for the new standards. Information on the open door forums is available on the CMS Web site at *http://www.cms.hhs.gov/OpenDoorForums/*.

Information about e-mail list updates is available on that same site at *http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/*.

In addition, a fact sheet on HIPAA 5010 is available on the CMS Web site at *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3246&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date*.

Finally, you can read the proposed rule in the *Federal Register*, Vol. 73, No. 164, Friday, August 22, 2008 at *http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf*; and the final rule in the *Federal Register*, Vol. 74, No. 11, Friday, January 16, 2009, on the CMS Web site at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*.

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

MLN Matters® Number: SE0904
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 SE0904

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
June 2009 – July 2009

Topic – Non-emergency ambulance benefit

When: Tuesday, June 16, 2009
Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida

Topic: ForeSee result survey

When: Wednesday, June 17, 2009
Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Hot Topic Series – Medicare 2009 updates and changes

When: Wednesday, July 15, 2009
Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida and U.S. Virgin Islands

Topic – Medifest educational event – Orlando, Florida

When: Tuesday and Wednesday, September 1 and 2, 2009
Time: 8:00 a.m. – 5:30 p.m. ET **Delivery language:** English
Type of Event: In person seminar/symposium **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

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, *medicare.fcso.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

May is Older Americans Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of Medicare-covered preventive services that may help older Americans live longer, fuller, healthier lives.

Medicare provides coverage for a variety preventive screenings. These screenings may help older Americans with Medicare stay healthy and detect conditions like cancer, glaucoma, and cardiovascular disease early when treatment works best.

CMS recognizes the crucial role the Medicare provider community plays in promoting and providing their patients information about potentially life-saving preventive services. Therefore, we have created a number of products available free of charge to help you educate yourselves and your patients about Medicare-covered preventive services, including:

MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network* (MLN) preventive services educational products and resources for health care professionals and their staff, and is available at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Preventive Services Brochures – provide information on bone mass measurements, cancer and glaucoma screenings, diabetes-related services, and expanded benefits, and is available at *http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf* (scroll down to "Brochures" and choose the desired link.)

Quick Reference Guides – provide additional information about initial preventive physical exams, immunization billing, and other preventive services, and is available at *http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf* (scroll down to "Quick Reference Information" and choose the desired link.)

Thank you for your support in helping CMS spread the word about the benefits of Medicare-covered preventive series that may help older Americans live longer, healthier lives. ❖

Source: CMS PERL 200905-24

Health care reminders for Mother's Day

The Centers for Medicare & Medicaid Services is asking the provider community to help keep women with Medicare healthy by ensuring that they take advantage of Medicare-covered preventive services. Medicare covers mammograms, bone mass measurements, screening pap tests, and screening pelvic exams, among other services, that can help women live longer, healthier lives.

The *Medicare Learning Network (MLN)* offers a variety of educational products related to Medicare-covered preventive services geared towards women. They include:

- Bone Mass Measurements brochure – provides information on Medicare coverage of bone-mass measurements and is available at *http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass.pdf*.
- Cancer Screenings brochure – provides information on Medicare coverage of cancer screenings, including screening mammography, screening pelvic exams, and screening pap tests and is available at *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.

For additional educational products, including quick reference guides and Web-based training courses, please visit the Medicare Preventive Services MLN products Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*. ❖

Source: CMS PERL 200905-07

May 19 is World Hepatitis Day

Hepatitis B is a highly infectious disease caused by the hepatitis B virus (HBV). Chronic HBV infection can lead to cirrhosis of the liver, liver cancer, liver failure, and death.

Medicare covers the hepatitis B vaccine and its administration for Medicare beneficiaries with an intermediate to high risk of contracting the disease. The Centers for Medicare & Medicaid Services (CMS) has created several educational products to help Medicare providers understand this benefit, including:

- **The Adult Immunizations brochure** – provides coverage information for the hepatitis B vaccine *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*.
- **The Medicare Preventive Services Quick Reference Information: Medicare Part B Immunization Billing Chart** – provides billing and coding information for the hepatitis B vaccine *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

For more information about Medicare-covered preventive services, including the hepatitis B vaccine, please visit the preventive services page on the Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200905-25

OTHER EDUCATIONAL RESOURCES

Revised federally qualified health center fact sheet

The revised federally qualified health center fact sheet (April 2009), which provides information about federally qualified health center (FQHC) designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC payments; and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf*. ❖

Source: CMS PERL 200904-31

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 administrative 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://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.

Order form for Medicare Part A materials

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to FCSO Account # (use appropriate account number)

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Non-provider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

Please write legibly	Subtotal	**$**
	Tax (***add % for your area***)	**$**
	Total	**$**

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Cost Report Settlement (payments due to provider or program)
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CMS-855 Applications
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Medicare Provider Enrollment – ADA
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Jacksonville, FL 32231-0048

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Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

RAILROAD MEDICARE
Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
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Oral Anti-Cancer Drugs
CIGNA Goverment Services
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Nashville, Tennessee 37202

Telephone Numbers

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1-888-664-4112

Interactive voice response (IVR)
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Option 2
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Option 3
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Florida Medicare Contractor
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Centers for Medicare & Medicaid Services
www.cms.hhs.gov

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