MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

[ ] Medicare Manager
[ ] Reimbursement Director
[ ] Chief Financial Officer
[ ] Compliance Officer
[ ] DRG Coordinator
[ ] ____________________
[ ] ____________________
[ ] ____________________

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

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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

Implementation of the redesigned provider statistical and reimbursement system

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 claims to Medicare administrative contractors (MACs) or fiscal intermediaries (FIs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6519, which notifies providers that the Centers for Medicare & Medicaid Services (CMS) has redesigned the provider statistical and reimbursement system (PS&R) and the new system is now operational. Be sure that your reimbursement staffs are aware of these changes.

Background

CR 6519 describes changes to the provider statistical & reimbursement (PS&R) system. This is a CMS system that accumulates and reports Medicare Part A claims data into categories needed for Medicare cost reporting. Providers utilize PS&R reports to accumulate statistical and payment data to prepare their Medicare cost reports, and FIs and MACs use this data to settle the cost reports.

The current PS&R system (legacy PS&R) has been in use for over twenty years. CMS has redesigned the system and it is now operational. The PS&R redesign is a centralized, Web-based application programmed using current technology. It includes enhancements that will improve access and delivery, as well as increase the system flexibility.

Key points of change request 6519

- The PS&R redesign will be utilized for filing and settling all cost reports with fiscal years ending on January 31, 2009, and later. Cost reports with fiscal years ending prior to January 31, 2009, will continue to be filed and settled with the legacy PS&R system. Due to this transition, the legacy PS&R will not produce reports containing dates of service after January 30, 2009. Reports for fiscal years containing claims with a service through date of January 31, 2009, and later must be produced by the PS&R redesign.
- If you receive interim PS&R reports, you may experience a short interruption in obtaining your interim reports during this transition. Interim reports are not a requirement and are not necessary for cost reporting. The transition to the PS&R redesign will not impact or delay submission of cost reports.
- The PS&R redesign will allow all users (providers, FIs/MACs, CMS) the ability to download summary PS&R reports via the Internet. Users will be able to log on to the system and request their summary reports on an as-needed basis. FIs/MACs will no longer produce and distribute these summary reports to their providers. It will be the provider's responsibility to obtain their own reports needed for their cost report. Providers will also be able to request detailed PS&R reports (reconciliation reports) via the internet, but due to the sensitive data contained within these reports, the FIs/MACs will continue to securely deliver these reports to providers. FIs/MACs may continue to charge a reasonable fee for the generation of the detail reports, in excess of one per year.
- The PS&R redesign on the CMS Web site Web page is located at *http://www.cms.hhs.gov/PSRR/*.

  This site contains an overview of the system, user manuals, quick guides, and other helpful information.
- The PS&R redesign will utilize individuals authorized access to CMS computer systems (IACS) for authentication and security purposes. All users must first establish an IACS account and also be approved for PS&R access prior to attempting to access the PS&R redesign. IACS allows users to obtain one ID and password needed to access multiple Web-based systems, one of which is the PS&R system. Information regarding the IACS process is located on the CMS Web site at *http://www.cms.hhs.gov/IACS*.
  The IACS Web page contains descriptions of the processes and links to user guides that will assist with registration. There are also *MLN Matters*® articles that may provide additional guidance on the use of IACS. Those articles are on the CMS Web site at:

  http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf

  http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf

  http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf.
- Providers and Medicare contractors must use IACS to gain access to the PS&R redesign. The Provider IACS verification process includes the submission of supporting documentation, and may take weeks to complete the entire process. Providers should begin their IACS registration using the following schedule, to ensure that they will be able to access IACS and PS&R well in advance of the cost report due date:

Implementation of the redesigned provider statistical and reimbursement system (continued)

Cost Report Fiscal Year End	Begin IACS Registration
January 31, 2009 – April 30, 2009	As soon as possible
May 1, 2009 – June 30, 2009	June 1, 2009
July 1, 2009 – August 31, 2009	August 1, 2009
September 1, 2009 – September 30, 2009	September 1, 2009
October 1, 2009 – January 30, 2010	November 1, 2009

- The PS&R Web page, *http://www.cms.hhs.gov/PSRR/*, contains a "Registration Tips" document that should assist with the addition of PS&R access to the user's IACS account. The document is located in the "Download" section of the Provider Community and FI/MAC Community links.
- Note that the first person to register for a provider organization must be the provider's designated security official (SO). This person is then responsible for all other users in that provider's organization. As soon as the SO registers, submits all documentation, and receives approval from CMS, that SO may then approve other users within his/her organization to access IACS to the PS&R system. While the SO may approve users for access to IACS and the PS&R, the SO cannot access the PS&R application.
- If the provider and SO have previously registered for another IACS application, they need not complete the initial registration again.
- If a provider is part of a chain, each provider within the chain must register separately.
- If an SO represents multiple providers, they may add the additional providers to their IACS account without having a separate IACS account for each provider. However, each provider will be vetted using the normal CMS approval process.
- To register in IACS, go to *https://applications.cms.hhs.gov* and read the warning message, then click "Enter CMS Applications Portal" and click the "Account Management" tab. This last click takes you to IACS Web-based training and a link for "New User Registration". Select the "Provider/Supplier Community" to begin the process.
- Providers must produce the summary PS&R reports needed to file cost reports ending on or after January 31, 2009. There are many variations of report requests that can be made in the new system, which you may customize as you become familiar with the system (see user guides and training materials).
- Providers approved for IACS will access the PS&R application on the CMS Website at *https://psr-ui.cms.hhs.gov/psr-ui*.
- The earliest data accessible in PS&R redesign is one full year of service dates beginning with the first cost report period ending January 31, 2009, and later (i.e. a June 30, 2009, fiscal year end provider's first accessible data is July 1, 2008 – June 30, 2009). CMS suggests you use a paid-through date that is approximately 30 days prior to the due date of your cost report. This will ensure that claims which may have been paid after the fiscal year end will be included in the PS&R. CMS also encourages you to attempt to run reports in advance to ensure that you can access the data needed for your cost report.
- Within the PS&R redesign, users will find Web-based training (WBT), help screens, and user manuals that will assist you in becoming more familiar with the system.
- Chapter 8 of the *Medicare Financial Management Manual* has been modified to include the updated information pertaining to the PS&R redesign. That revision is attached to CR 6519. The PS&R technical information, located in Chapter 9 of that manual will be modified soon to include PS&R redesign specific information.
- Any user that has questions regarding IACS should contact the IACS help desk, External User Services (EUS), at 866-484-8049, or EUSSupport@cgi.com. Any providers' PS&R application specific questions will continue to be directed to their FI/MAC.

Additional information

The official instruction (CR 6519) issued to your Medicare MAC and/or FI is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R153FM.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: MM6519
Related Change Request (CR) Number: 6519
Related CR Release Date: June 12, 2009
Related CR Transmittal Number: R153FM
Effective Date: July 13, 2009
Implementation Date: July 13, 2009

Source: CMS Pub. 100-06, Transmittal 153, CR 6519

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July 2009 update to the Medicare physician fee schedule database

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6484, which amends payment files that were issued to Medicare contractors based on the 2009 MPFS final rule. Be sure billing staff are aware of the *Current Procedure Terminology* (*CPT*)/Healthcare Common Procedure Coding System (HCPCS) changes made in this July Update to the 2009 MPFSDB.

Background

Payment files were issued to contractors based upon the 2009 MPFS final rule. CR 6484 amends those payment files. Changes included in the July Update to the 2009 MPFSDB are as follows:

The following changes are effective for dates of service on and after January 1, 2009:

CPT/HCPCS	Action
50593	Bilateral indicator = 1
77421	Global physician supervision diagnostic indicator = 09
77421TC	Physician supervision diagnostic indicator = 02
92025	Global bilateral indicator = 2
92025TC	Bilateral indicator = 2
9202526	Bilateral indicator = 2

Note: Changes to *CPT* code *93351* were included in the April update to the MPFSDB. Fully implemented facility practice expense relative value units (PE RVUs) were inadvertently not listed in Attachment 1 of the April update but were included on the payment files. Included are the fully implemented facility PE RVUs for *CPT* code *93351*. This service is typically not paid under the Medicare physician fee schedule when provided in a facility setting and the fully implemented facility PE RVUs listed below are informational only.

93351 Global Fully implemented facility PE RVU: 5.07

93351 TC Fully implemented facility PE RVU: 4.15

93351 26 Fully implemented facility PE RVU: 0.92

The following changes are effective for dates of service on and after July 1, 2009:

CPT/HCPCS	Action
90670	Long Descriptor: *Pneumococcal conjugate vaccine, 13 valent, for intramuscular use* Short descriptor: Pneumococcal vacc, 13 val im Procedure Status: X
92507	PC/TC indicator = 7
92508	PC/TC indicator = 7
92526	PC/TC indicator = 7
92597	PC/TC indicator = 7
92607	PC/TC indicator = 7
92608	PC/TC indicator = 7
92609	PC/TC indicator = 7
96125	PC/TC indicator = 7
0199T	Long descriptor: *Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report* Short descriptor: Physiologic tremor record Procedure Status: C

July 2009 update to the Medicare physician fee schedule database (continued)

CPT/HCPCS	Action
0200T	Long descriptor: *Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles* Short descriptor: Perq sacral augmt unilat inj Procedure Status: C
0201T	Long descriptor: *Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles* Short descriptor: Perq sacral augmt bilat inj Procedure Status: C
0202T	Long descriptor: *Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine* Short descriptor: Post vert arthrplst 1 lumbar Procedure Status: C
Q2023	Long descriptor: Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per IU. Short descriptor: Xyntha, inj Procedure Status: E
Q4115	Long descriptor: Skin substitute, alloskin, per square centimeter Short descriptor: Alloskin skin sub Procedure Status: E
Q4116	Long descriptor: Skin substitute, alloderm, per square centimeter Short descriptor: Alloderm skin sub Procedure Status: E

Additional information

The official instruction, CR 6484, issued to your Medicare carrier, FI and/or MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1748CP.pdf*.

If you have questions, please contact your Medicare carrier, 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: MM6484
Related Change Request (CR) Number: 6484
Related CR Release Date: May 29, 2009
Related CR Transmittal Number: R1748CP
Effective Date: January 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1748, CR 6484

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July 2009 quarterly update to drug and biological HCPCS codes

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

Provider types affected

Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors (DME MACs) for drugs and biologicals provided to Medicare beneficiaries.

Provider action needed

This article explains updates, effective for dates of service on or after July 1, 2009 (unless otherwise specified), to HCPCS codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background

The HCPCS code set is updated on a quarterly basis. This article describes updates for specific drug/biological HCPCS codes. Effective for claims with dates of service on or after July 1, 2009, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description	TOS code	MPFSDB* status indicator
Q2023	Xyntha, inj	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per i.u.	1	E
Q4115	Alloskin skin sub	Skin substitute, alloskin, per square centimeter	1	E
Q4116	Alloderm skin sub	Skin substitute, alloderm, per square centimeter	1	E

* MPFSDB – Medicare physician fee schedule database

The Medicare coverage indicator for the following codes was incorrectly listed on the January 2009, HCPCS code set file. With the July 2009 quarterly update to the HCPCS code set, Medicare is correcting the file to show a Medicare coverage indicator of the letter "D". The letter "D" indicates that "special coverage instructions apply" and the applicable special coverage instructions are provided in the local coverage determinations (LCD) regarding inhalation drugs. These updates are based on change request (CR) 5981 and are effective for claims with dates of service on or after April 1, 2008. Note that Medicare contractors will not search for and adjust claims processed before this change is implemented. However, they will adjust such claims that you bring to their attention.

HCPCS code	Short description	Medicare coverage indicator
J7611	Albuterol non-comp con	D
J7612	Levalbuterol non-comp con	D
J7613	Albuterol non-comp unit	D
J7614	Levalbuterol non-comp unit	D

Additional information

The official instruction, CR 6477, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1752CP.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.zi*p.

MLN Matters® Number: MM6477
Related Change Request (CR) Number: 6477
Related CR Release Date: June 5, 2009
Related CR Transmittal Number: R1752CP
Effective Date: July 1, 2009, except as noted in article
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1752, CR 6477

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FDA consumer alert: Warning consumers of a tainted skin sanitizer

Following an announcement by the U. S. Food and Drug Administration (FDA)-warning consumers of a tainted skin sanitizer, the Centers for Medicare & Medicaid Services (CMS) is advising health care providers and consumers not to use skin products made by Clarcon Biological Chemistry Laboratory. Clarcon is voluntarily recalling some skin sanitizers and skin protectants marketed under several different brand names because of high levels of disease-causing bacteria found in the product during a recent inspection.

Consumers and providers are being warned to not use any Clarcon products and to throw these products away in household refuse.

FDA analyses of several samples of Clarcon products revealed high levels of various bacteria, including some associated with unsanitary conditions. Some of these bacteria can cause opportunistic infections of the skin and underlying tissues. Such infections may need medical or surgical attention, and may result in permanent damage. Examples of products that should be discarded include:

- Citrushield lotion
- Dermasentials dermabarrier
- Dermassentials by Clarcon antimicrobial hand sanitizer
- Iron fist barrier hand treatment
- Skin shield restaurant
- Skin shield industrial
- Skin shield beauty salon lotion
- Total skin care beauty
- Total skin care work

Health care professionals and consumers may report serious adverse events (side effects) or product quality problems with the use of this product to the FDA's MedWatch Adverse Event Reporting program either online, by regular mail, fax, or phone.

- Online
- Regular mail: use postage-paid FDA form 3500 and mail to MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787
- Fax: 800-FDA-0178
- Telephone: 800-FDA-1088

For more information access *http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm164845.htm*. ❖

Source: CMS PERL 200906-24

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Information to include in your membership communications

Help your association members stay up-to-date on the latest Medicare-related information. Below is a brief news item that Medicare encourage you to put in your next newsletter, bulletin, or whatever vehicle you use to provide your members with news they need to know. Through their electronic mailing lists, Medicare contractors serve as a valuable source of news and information regarding Medicare business in specific provider practice locations, including local coverage determinations and local provider education events:

> "Did you know that your local Medicare contractor is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor Web site and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for "listserv" or "e-mail list" to find the registration page. If you do not know the Web address of your contractor's home page, it is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
>
> The Web address for First Coast Service Options Inc. is *http://medicare.fcso.com/index.asp*."

Do your members a favor and help Medicare spread the word. ❖

Source: CMS PERL 200906-02

New fact sheet for general equivalence mappings to and from ICD-9-CM and ICD-10-CM/PCS

The second in a series of fact sheets regarding general equivalence mapping (GEM) to and from ICD-9-CM and ICD-10-CM/PCS is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctsht.pdf*.

This GEM fact sheet, published in May 2009, provides basic information about general equivalence mappings including possible users of the GEMs, why the GEMs are needed, and how the GEM files are formatted as well as reimbursement mappings information. ❖

Source: CMS PERL 200906-07

Transcripts for May 19 ICD-10-CM/PCS conference call available

The written and audio transcripts of the ICD-10-CM/PCS implementation and general equivalence mappings (crosswalks) national provider conference call, which was conducted by the Centers for Medicare & Medicaid Services on May 19, 2009, are now available in the *Downloads* section at *http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp*. ❖

Source: CMS PERL 200906-18

Influenza pandemic emergency—the Medicare program prepares

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 this *MLN Matters* article special edition SE0836 to include a Web link to change request (CR) 6284, which was recently issued by CMS. All other information remains the same. The *MLN Matters* article SE0836 was published in the December 2008 Medicare *A Bulletin* (page 16).

Provider types affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], durable medical equipment Medicare administrative contractors [DME MACs], carriers or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Impact on providers

This article is informational only and is alerting providers that the CMS) has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that **may** be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act.
2. The Secretary of the Department of Health & Human Services declares – under Section 319 of the Public Health Service Act – that a public health emergency exists.
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to Section 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web page now available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp*.

That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional information

Additional CMS influenza pandemic policy documents include:

- CR 6146, which may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf*.
- CR 6164, which may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf*.
- CR 6174, which may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf*.
- CR 6209, which is available on the CMS Web site at *http://cms.hhs.gov/Transmittals/downloads/R411OTN.pdf*.
- CR 6256, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R428OTN.pdf*.
- CR 6280, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R441OTN.pdf*.
- CR6284, which is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R439OTN.pdf*.
- CR 6378, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R454OTN.pdf*.

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

MLN Matters Number: SE0836 – 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 SE0836

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Discontinuance of the unique physician identification number registry

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 MM5584 to remove the link to the unique physician identification number (UPIN) registry, which is no longer maintained, also to remove another link to the national provider identifier (NPI) contingency plan that no longer works as the information is not maintained anymore on the Internet. All other information is the same. The *MLN Matters* article MM5584 was published in the October 2007 *Medicare A Bulletin* (pages 11-12).

Provider types affected

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

Provider action needed

STOP – impact to you

This article is based on change request (CR) 5584, which announces that the Centers for Medicare & Medicaid Services (CMS) discontinued assigning UPINs on June 29, 2007.

CAUTION – what you need to know

The NPI is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare fee-for-service [FFS] contingency plan UPINs, and surrogate UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.)

GO – what you need to do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the national plan and provider enumeration system (NPPES) Web site at *https://nppes.cms.hhs.gov/*.

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

Background

CMS was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health & Human Services published a final rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the NPI. The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007, (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007.

CMS discontinued assigning UPINs on June 29, 2007. CMS published the NPPES data dissemination notice (CMS-6060-N) in the *Federal Register* on May 30, 2007. This notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the NPPES.

Additional information

For additional information regarding NPI requirements and use, please see *MLN Matters* articles, MM4023 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*) titled "Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms," and MM4293 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf*) titled "Revised CMS-1500 Claim Form," which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the NPI and renamed CMS-1500 (08-05).

The official instruction (CR 5584) issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf*.

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

MLN Matters Number: MM5584 – Revised
Related Change Request (CR) Number: 5584
Related CR Release Date: September 14, 2007
Related CR Transmittal Number: R222PI
Effective Date: May 29, 2007
Implementation Date: June 29, 2007

Source: CMS Pub. 100-08, Transmittal 222, CR 5584

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July 2009 update for durable medical equipment, prosthetics, orthotics, and supplies

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6511 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is located in Section 60, Chapter 23 of the *Medicare Claims Processing Manual* and is located on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

Other information on the fee schedule, including access to the DMEPOS fee schedules is on the CMS Web site at *http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp*.

Key points of change request 6511

The following table identifies the 2009 fees for the Healthcare Common Procedure Codes System (HCPCS) codes K0739/E1340.

State	K0739/E1340
AK*	25.27
AL*	13.41
AR*	13.41
AZ*	16.59
CA*	20.58
CO*	13.41
CT*	22.40
DC*	13.41
DE*	24.71
FL*	13.41
GA*	13.41
HI*	16.59
IA*	13.41
ID*	13.41
IL	13.41
IN	13.41
KS	13.41
KY	13.41
LA	13.41
MA*	22.40
MD	13.41
ME*	22.40
MI	13.41
MN	13.41
MO	13.41
MS	13.41
MT	13.41
NC	13.41
ND*	16.72
NE	13.41
NH*	14.40
NJ*	18.10
NM*	13.41
NV*	21.37
NY*	24.71
OH*	13.41
OK	13.41
OR	13.41
PA*	14.40
PR	13.41
RI*	15.99
SC	13.41
SD*	14.99
TN	13.41
TX	13.41
UT*	13.45
VA	13.41
VI	13.41
VT*	14.40
WA*	21.37
WI	13.41
WV	13.41
WY*	18.70

* Denotes revised for the 2009 fee schedule

July 2009 update for durable medical equipment, prosthetics, orthotics, and supplies (continued)

- The 2009, allowed payment amounts for HCPCS codes E1340/K0739 are revised as part of this quarterly update to reflect updates that were brought to CMS' attention. The allowed payment amounts (listed above) for codes E1340/K0739 are effective as follows:
  - For claims with dates of service from January 1, 2009, through March 31, 2009, submitted using HCPCS code E1340 (Repair or non-routine service for DME requiring the skill of a technician, labor component, per 15 minutes).
  - For claims with dates of service from April 1, 2009, through December 31, 2009, submitted using HCPCS code K0739 (Repair or non-routine device for DME other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes).
- Medicare contractors will adjust previously processed claims for HCPCS code E1340/K0739 with dates of service on or after January 1, 2009, through June 30, 2009, if they are resubmitted as adjustments.
- HCPCS codes A6545, E0656, E0657 and L0113 were added to the HCPCS file effective January 1, 2009. The fee schedule amounts for these HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2009. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for the above codes with dates of service on or after January 1, 2009, which have already been processed, will not be adjusted** to reflect the newly established fees if they are resubmitted for adjustment.
- As part of this update CMS is adding the modifier AW to the fee schedule file for HCPCS code A6545 (Gradient compression wrap, non-elastic, below knee, 30-50 MM HG, each). HCPCS code A6545 is covered when it is used in the treatment of an open venous stasis ulcer. Currently, HCPCS code A6545 is noncovered for the following conditions:
  - Venous insufficiency without stasis ulcers, prevention of stasis ulcers, prevention of the reoccurrence of stasis ulcers that have healed, and treatment of lymphedema in the absence of ulcers. In these situations, since an ulcer is not present, the gradient compression wraps do not meet the definition of a surgical dressing. **Suppliers are advised that when the non-elastic gradient compression wrap HCPCS code A6545 is used in the treatment of an open venous stasis ulcer, it must be billed with the modifier AW.** Claims for HCPCS code A6545 that do not meet the covered indications should be billed without the modifier AW and as such, will be denied as noncovered.
- As part of this update, the fee schedule amounts for HCPCS code K0606 (Automatic external defibrillator, with integrated electrocardiogram analysis, garment type) billed without the modifier KF are being removed from the DMEPOS fee schedule file.
- A one-time notification regarding the changes in payment for oxygen and oxygen equipment as a result of the MIPPA of 2008 and additional instructions regarding payment for DMEPOS was issued on December 23, 2008, (transmittal 421, CR 6297). A related *MLN Matters*® article may be reviewed on the CMS Web site at *http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6297.pdf*). CR 6297 included 2009, labor payment rates for HCPCS codes E1340, L4205 and L7520.
- In 2009, code K0739 was established in the HCPCS file to replace code E1340 for Medicare claims for the repair of beneficiary-owned DME with dates of service on or after April 1, 2009, (see transmittal 443, CR 6296 issued on February 13, 2009, which may be reviewed on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R443OTN.pdf*). The 2009 allowed payment amounts for HCPCS code E1340 mapped directly to code K0739.

Additional information

For complete details regarding this CR please see the official instruction (CR 6511) issued to your Medicare MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1754CP.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: MM6511
Related Change Request (CR) Number: 6511
Related CR Release Date: June 5, 2009
Related CR Transmittal Number: R1754CP
Effective Date: January 1, 2009, for implementation of fee schedule amounts for codes in effect then; April 1, 2009, for code K0739; July 1, 2009, for all other changes
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1754, CR 6511

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Get ready for the DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round one re-bid is coming soon.

Summer 2009

- The Center for Medicare & Medicaid Services (CMS) announces bidding schedule/schedule of education events
- CMS begins bidder education campaign
- Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait

Update your national supplier clearinghouse (NSC) files: DMEPOS supplier standard # 2 requires all suppliers to notify the NSC of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update the following sections:

- list of products and services found in section 2.D
- authorized official(s) information in sections 6A and 15
- correspondence address in section 2A2

This is especially important for suppliers who will be involved in the Medicare DMEPOS competitive bidding program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC Web site (*http://www.palmettogba.com/nsc*) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get licensed: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get accredited: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of six months to complete. DMEPOS suppliers should contact a CMS deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS Web site: *http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Get bonded: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009, deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties from which a bond may be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies"; the Web site is located at: *http://www.fms.treas.gov/c570/c570_a-z.html*.

Visit the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* for the latest information on the DMEPOS competitive bidding program.

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

Source: CMS PERL 200906-12

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Reminder: Time is running out for DMEPOS supplier accreditation

Deadline is September 30, 2009

Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. While the accreditation process takes on average six to seven months to complete, the process could take as long as nine months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary) must comply with the Medicare program's supplier standards and quality standards to become accredited. The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, and prosthetics and orthotics.

Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation. Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals/other persons exempted from accreditation may be found at the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*. ❖

Source: CMS PERL 200906-01

What's new with 2009 PQRI and e-Prescribing incentive programs

New educational resource article on the 2009 Physician Quality Reporting Initiative (PQRI) and electronic prescribing (e-Prescribing) programs

A new educational resource article has been posted to the PQRI Web page on the CMS Web site. The article titled *Physician Quality Reporting Initiative (PQRI) & e-Prescribing: Implementation Advice for the Office Manager* outlines step-by-step how to get started in reporting 2009 PQRI measures and is available at *http://www.cms.hhs.gov/PQRI/31_PQRIToolKit.asp* on the CMS Web site as a downloadable document. Scroll down to the *Downloads* section and select *2009 PQRI and E-Prescribing Implementation Advice* link.

Three available PQRI help desk resources

The following resources are available to assist eligible professionals with their questions on the PQRI initiative:

Provider call center directory

- Remittance advice notices
- Incentive payment distribution status
- Adjustments made to incentive payment due to sanctions/overpayments

For contact information, see the *Provider Center Toll-free Numbers Directory*, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

External user services (EUS) – 7:00 a.m.-7:00 p.m. (ET)

- Registering/creating an IACS account
- Accessing an IACS account
- Changing an IACS account
- Approving users into an organization

Phone: 1-866-484-8049
TTY: 1-866-523-4759

QualityNet help desk – 7:00 a.m.-7:00 p.m. (CT)

- General CMS PQRI and e-Prescribing information
- PQRI portal password issues
- PQRI feedback report availability and access

Phone: 1-866-288-8912

Related links

- Information on the CMS PQRI initiative may be found on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.
- Information on the CMS e-Prescribing incentive program may be found on the CMS Web site at *http://www.cms.hhs.gov/ERxIncentive*.

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

Source: CMS PERL 200905-36

General Coverage

Coding and Medicare payment decision for negative pressure wound therapy devices

The Centers for Medicare & Medicaid Services (CMS) preliminary Healthcare Common Procedure Coding System (HCPCS) coding and preliminary Medicare payment decisions for negative pressure wound therapy (NPWT) devices are now published in the July 9, 2009, NPWT public meeting agenda. This public meeting affords stakeholders an opportunity to provide input concerning the preliminary decision.

The Medicare Improvements for Patients and Providers Act of 2008 required the Secretary to evaluate existing HCPCS codes for NPWT devices to ensure accurate reporting and billing for the items and services under such codes, use an existing process for the consideration of coding changes, and consider all relevant studies and information furnished through the process.

CMS partnered with the Agency of Healthcare Research and Quality (AHRQ) to commission a review of NPWT devices to ensure all relevant studies and information on NPWT were captured. The Economic Cycle Research Institute (ECRI) solicited information from stakeholders and searched literature in conducting this review. A draft report of their findings was published for comment in April 2009. After analysis of comments received, ECRI concluded that the available evidence does not support significant therapeutic distinction of an NPWT system or component of a system. The report summarizes the decision made by the CMS HCPCS workgroup. The final report was publicly available on June 10, 2009, on the AHRQ's homepage for the technology assessment program at *http://www.ahrq.gov/clinic/techix.htm*. ❖

Source: CMS PERL 200906-16

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Local Coverage Determinations

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

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ADDITIONS/REVISIONS TO EXISTING LCDs

AJ0740: Ganciclovir and cidofovir – revision to the LCD

LCD ID Number: L28846 (Florida)
LCD ID Number: L28879 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ganciclovir and cidofovir was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. The off-label indication of BK nephropathy and BK viremia has been added as medically reasonable for HCPCS code J0740. The "Indications and Limitations of Coverage and/or Medical Necessity," "Documentation Requirements," and "Utilization Guidelines" sections of the LCD have been revised accordingly. In addition, the following ICD-9-CM code has been added for HCPCS code J0740 as medically reasonable for this off-label indication: V42.0 (Organ or tissue replaced by transplant, kidney).

Effective date

This LCD revision is effective for services provided **on or after June 25, 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. ❖

AJ9350: Topotecan hydrochloride (Hycamtin®) – revision to the LCD

LCD ID Number: L28993 (Florida)
LCD ID Number: L29025 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for topotecan hydrochloride (Hycamtin®) was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. A request was received to add the off-label indication of primary central nervous system lymphoma as medically reasonable and necessary. Review of literature demonstrated that this was an acceptable request. Therefore the "Indications and Limitations of Coverage and/or Medical Necessity," "Utilization Guidelines," and "ICD-9 Codes that Support Medical Necessity" sections of the LCD have been revised accordingly. The following ICD-9-CM code range has been added as medically reasonable and necessary: 200.50-200.58.

Effective date

This LCD revision is effective for services provided **on or after June 25, 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. ❖

ANCSVCS: The list of Medicare noncovered services – revision to the LCD

LCD ID Number: L28991 (Florida)
LCD ID Number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the list of Medicare noncovered services was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. First Coast Service Options Inc. (FCSO) received a request to remove *CPT* code *0193T (Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence)*, which includes the Renessa® treatment for women with stress urinary incontinence, from the list of Medicare noncovered services LCD.

With emerging technologies that are billed to the Medicare contractor as either an unlisted procedure code or, when applicable, a category III *CPT* code, FCSO addresses the procedure billed as:

1. Not medically necessary and not covered; or
2. Medically necessary per certain criteria as indicated in the development and communication of a LCD; or
3. As is frequently the case, as we learn about the technology based on how it is billed and what has been published in the peer-reviewed literature, we will have no positive coverage statement and claims will be handled on an individual case by case basis.

ANCSVCS: The list of Medicare noncovered services – revision to the LCD (continued)

FSCO is not issuing a positive coverage statement at this time regarding the Renessa® procedure. However, in order to provide an option for those physicians who are appropriately trained in treating women with stress urinary incontinence (SUI) and who are appropriately trained in performing the Renessa® procedure, we will be removing Renessa® from our noncovered LCD and will be looking at claims for the Renessa® procedure on an individual case by case basis.

The non-surgical Renessa® treatment, represented by *CPT* code *0193T* and ICD-9-CM code 625.6 (Stress urinary incontinence, female), has been approved by the Food and Drug Administration (FDA) since July 22, 2005, and is indicated for the transurethral treatment of female SUI due to hypermobility in women who have failed conservative treatment and who are not candidates for surgical therapy. FCSO expects that providers submitting claims for Renessa® are providing the services within the FDA approved guidelines and in accordance with the indications supported by peer-reviewed literature which limits its use to moderate to severe stress urinary incontinence (SUI) in females. In addition, for dates of service on or after January 1, 2009, Renessa® should no longer be reported with *CPT* code *53899 (Unlisted procedure, urinary system)*.

Effective date

This LCD revision is effective for services provided **on or after June 30, 2009.** FCSO 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. ❖

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ANCSVCS: The list of Medicare noncovered services – revision to the LCD

LCD ID Number: L28991 (Florida)
LCD ID Number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised effective June 30, 2009. Since that time, the LCD has been revised based on change request 6492 (July 2009 Update of the Hospital Outpatient Prospective Payment System [OPPS]), dated May 22, 2009.

The “Local Noncoverage Decisions – Devices” section of the LCD has been revised as follows:

Added *CPT* code *0199T* (*Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report*), as it is a screening procedure and is not medically reasonable and necessary.

Effective date

This LCD revision is effective for claims processed **on or after July 6, 2009,** for services provided **on or after July 1, 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. ❖

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Additional Medical Information

A95805: Polysomnography and sleep testing – extended date of accreditation

LCD ID Number: L29905 (Florida)
LCD ID Number: L29907 (Puerto Rico/U.S. Virgin Islands)

The new local coverage determination (LCD) for polysomnography and sleep testing that includes home sleep testing (HST) is effective for services provided on or after June 30, 2009, for Florida, Puerto Rico, and the U.S. Virgin Islands. A sleep facility must maintain documentation on file that indicates it is accredited by the American Academy of Sleep Medicine (AASM) or that it is accredited as a sleep laboratory by the Joint Commission. This documentation must be available to Medicare on request.

In regard to performing and billing the technical component (TC) of polysomnography (PSG) and sleep testing (including HST), sleep facilities (hospital based or affiliated) and free standing facilities (office/clinic, independent diagnostic testing facilities, and any non-hospital based facilities where sleep studies are performed) that are not currently accredited must be able to demonstrate that they are seeking accreditation (application sent and under review) or AASM provisional accreditation and are complying with all other standards of care outlined in the LCD. These facilities will have until April 30, 2010, to obtain the required accreditation.

However, physicians who review and interpret (professional component [PC]) PSG and sleep testing (including HST) must currently be in compliance with credentialing/training as outlined in the LCD:

- A diplomate of the American Board of Sleep Medicine (ABSM), or
- A diplomate in sleep medicine by a member board of the American Board of Medical Specialties (ABMS), or
- An active physician staff member of an AASM accredited sleep center or sleep laboratory, or
- An active physician staff member of a joint commission accredited sleep laboratory.

In addition, sleep technicians or technologists facilitating PSG and sleep testing or facilitating HST must have appropriate personnel certification. Examples of certification/training in PSG and sleep technology for nonphysician personnel include:

- Registered polysomnography technologist (RPSGT)
- Registered electroencephalographic technologist (R.EEG T.) – polysomnography

Credentialing for sleep technicians or technologists must be provided by nationally recognized credentialing organizations such as:

- Board of Registered Polysomnographic Technologists (BRPT) that provides (RPSGT) credential; or
- American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRET) that provides R. EEG T.) – polysomnography credential; or
- Performed in a sleep center or laboratory accredited by the AASM, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- ABSM that provides credentialing in sleep technology; or
- National Board for Respiratory Care, Inc. (NBRC) that provides specialty examination for respiratory therapists performing sleep disorders testing and therapeutic intervention (CRT-SDS and RRT-SDS)

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. ❖

0197T/77499: Calypso® 4D localization system™

Image guided radiation therapy (IGRT) is a technique in which imaging occurs during the course of a radiation therapy session (treatment delivery) in order to ensure that the radiation is delivered to the correct target location and avoid exposure of the surrounding tissues. The *current procedure terminology* book (*CPT*) has three codes with descriptors applicable to IGRT: *CPT* codes *77014*, (*Computed tomography guidance for placement of radiation therapy fields*); *77421*, (*Steroscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*); and *76950*, (*Ultrasonic guidance for the placement of radiation therapy fields*). Various emerging technologies of localization and tracking of patient or tumor motion are being studied, including 3D positional or surface tracking technology. This technology is reported using *CPT* code *77499* (*Unlisted procedure, therapeutic radiology treatment management*) for dates of service prior to January 1, 2009, and *CPT* code *0197T* (*Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy [e.g., 3D positional tracking, 3D surface tracking], each fraction of treatment*) for dates of service on or after January 1, 2009.

0197T/77499: Calypso® 4D localization system™ (continued)

The Calypso® 4D localization system™ used with Beacon® electromagnetic transponders is a real-time target localization and tracking system that has been approved by the Food and Drug Administration (FDA) since 2006 for use in the prostate and provides continuous target localization which aids in patient set-up and target tracking to monitor tumor position during radiation therapy delivery. The Beacon® electromagnetic transponders are designed to be used specifically with the Calypso® system to provide target localization and continuous real-time monitoring during radiation therapy for the prostate.

With emerging technologies that are billed to the Medicare contractor as either an unlisted procedure code or, when applicable, a category III *CPT* code, First Coast Service Options Inc. (FCSO) addresses the procedure billed as:

1. Not medically necessary and not covered; or
2. Medically necessary per certain criteria as indicated in the development and communication of a local coverage determination (LCD); or
3. as is frequently the case, as we learn about the technology based on how it is billed and what has been published in the peer-reviewed literature, we will have no positive coverage statement and claims are handled on a case by case basis.

FCSO does not have a positive coverage statement for *CPT* code *0197T* that describes the use of the Calypso® system during treatment delivery. FCSO has reviewed claims for emerging technologies such as the Calypso® system with Beacon® transponders in addition to current peer-reviewed literature and as of June 19, 2009, will no longer be reimbursing these procedures since there is no compelling data on the impact of this system on long term patient outcomes. Also, there is frequently static image guidance billed on the claim on the same day. In addition, some of these emerging technologies require the use of so called "smart fiducials" such as transponders or implantable tissue dosimeters. FCSO will not be paying for the additional cost of these "smart fiducials" and will only be covering gold markers. ❖

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C9399/J9999: Plerixafor (MOZOBIL®) – revision to article

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 consecutive days. MOZOBIL® may be billed to the Medicare contractor with HCPCS codes J3490 (Unclassified drugs), J9999 (Not otherwise classified, antineoplastic drugs) or effective for dates of service on or after July 1, 2009, may be billed with HCPCS code C9252 (Injection, plerixafor, 1 mg). For dates of service prior to July 1, 2009, HCPCS code C9399 could also be billed. In addition the list of ICD-9-CM codes that First Coast Service Options Inc. (FCSO) will consider as medically reasonable and necessary has been expanded to include all of the following:

200.00-200.08	200.10-200.18	200.20-200.28
200.30-200.38	200.40-200.48	200.50-200.58
200.60-200.68	200.70-200.78	200.80-200.88
202.00-202.08	202.10-202.18	202.20-202.28
202.30-202.38	202.40-202.48	202.50-202.58
202.60-202.68	202.70-202.78	202.80-202.88
202.90-202.98	203.00	203.01.

At this time, the only G-CSF that 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 four 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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Hospital Services

Correction to fiscal year 2009 Medicare-severity long-term care diagnosis-related group weights

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

Provider types affected

This article applies to long-term care hospitals (LTCHs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and which are paid under the LTCH prospective payment system (PPS).

Provider action needed

Change request (CR) 6552 alerts providers that the Centers for Medicare & Medicaid Services (CMS) will issue a new LTCH PPS PRICER for the remainder of this fiscal year (FY) that contains the revised relative weight table. CMS has instructed Medicare contractors to hold LTCH PPS claims with discharges on or after June 3, 2009 until the updated PRICER is in production. Be sure your billing staff is aware of this update.

Background

In an interim final rule with comment period (IFC) published in the *Federal Register* on June 3, 2009, CMS implemented revised MS-LTC-DRG relative weights for payment under LTCH PPS for federal FY 2009. The FY 2009 Medicare-severity long-term care diagnosis-related group MS-LTC-DRG relative weights were revised due to the misapplication of the established budget neutrality methodology. The revised FY 2009 MS-LTC-DRG relative weights presented in Table 11 of that IFC are effective for the remainder of the FY. To review Table 11 go to *http://www.cms.hhs.gov/LongTermCareHospitalPPS/Downloads/FY_2009_LTC-DRG_Weight_Table_(CMS-1337-IFC).zip* and open the Excel file that is retrieved at that link.

Note: This revision to the FY 2009 MS-LTC-DRG relative weights did not affect the calculation of the geometric mean length of stay and the short-stay outlier (SSO) threshold for FY 2009 that were presented in Table 11 of the FY 2009 IPPS final rule.

Key points

- The revised LTCH PRICER will be effective for discharges on or after June 3, 2009.
- The specific dates for the remainder of FY 2009 for LTCH PPS discharges are for those occurring on or after June 3, 2009 through September 30, 2009.
- Medicare contractors will release held claims for processing once the LTCH PRICER is in production.

Additional information

The official instruction, CR 6552, issued to your Medicare FI or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1758CP.pdf*.

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

MLN Matters® Number: MM6552
Related Change Request (CR) Number: 6552
Related CR Release Date: June 19, 2009
Related CR Transmittal Number: R1758CP
Effective Date: June 3, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1758, CR 6552

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Proposed rate year 2010 Medicare-severity long-term care diagnosis-related group relative weights and high-cost outlier fixed-loss amount

The supplemental proposed rule CMS-1406-P2 presents both proposed rate year (RY) 2010 Medicare- severity-long-term care diagnosis-related group (MS-LTC-DRG) relative weights and a proposed RY 2010 high cost outlier (HCO) fixed-loss amount based on the revised fiscal year (FY) 2009 MS-LTC-DRG relative weights presented in an interim final rule with comment period published elsewhere in the *Federal Register*.

The supplemental proposed rule CMS-1406-P2 may be found in text or PDF version under “Related Links Outside CMS” on the CMS Web site at *http://www.cms.hhs.gov/LongTermCareHospitalPPS/LTCHPPSRN/itemdetail.asp?itemID=CMS1222248*. ❖

Source: CMS PERL 200906-08

Update to the inpatient psychiatric facility prospective payment system rate year 2010

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

Provider types affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the inpatient psychiatric facility prospective payment system (IPF PPS).

Impact on providers

Change request (CR) 6461, from which this article is taken, identifies changes required as part of the annual inpatient psychiatric facility (IPF PPS) update for rate year (RY) 2010. These changes are effective July 1, 2009, and are applicable to IPF discharges occurring during the RY beginning on July 1, 2009, through June 30, 2010. This is the fourth RY update to the IPF PPS. The applicable previous year update is detailed in *MLN Matters®* article MM6077 and may be reviewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6077.pdf*.

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

Background

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

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

CMS is required to update this IPF PPS annually. The RY update is effective July 1 to June 30 of each year and the Medicare severity-diagnosis related groups (MS-DRGs) and ICD-9-CM codes are updated on October 1 of each year.

Key points

Market basket update

CMS uses the rehabilitation/psychiatric/long-term care (RPL) market basket to update the IPF PPS portion of the blended payment rate (that is the federal per diem base rate).

PRICER updates

For the IPF PPS RY 2010, (July 1, 2009, to June 30, 2010) the following are effective for discharges on July 1, 2009, through June 30, 2010:

- The federal per diem base rate is $651.76
- The fixed dollar loss threshold amount is $6,565.00
- The IPF PPS will use the FY 2009 unadjusted pre-floor, pre-reclassified hospital wage index
- The labor-related share is 75.89 percent
- The non-labor related share is 24.11 percent
- The electroconvulsive therapy (ECT) rate is $280.60.

Cost to charge ratios

The national urban and rural cost-to-charge ratios (CCR) for the IPF PPS RY 2010 are displayed in the following table:

Cost to charge ratio	Median	Ceiling
Urban	0.5300	1.7647
Rural	0.6515	1.7381

CMS is applying the national median CCRs to the following situations:

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

MS-DRG update

The code set and adjustment factors are unchanged for RY 2010.

Note: For the FY 2009 pre-floor, pre-reclassified hospital wage index CMS is using the updated wage index and the wage index budget neutrality factor of 1.0009.

Additional information

To see the official instruction (CR 6461) issued to your Medicare FI or A/B MAC, visit the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1741CP.pdf*.

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

MLN Matters® Number: MM6461
Related Change Request (CR) Number: 6461
Related CR Release Date: May 22, 2009
Related CR Transmittal Number: R1741CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1741, CR 6461

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Inpatient psychiatric facility prospective payment system personal computer PRICER corrections

Corrections were made to the inpatient psychiatric facility prospective payment system (IPF PPS) personal computer (PC) PRICER for FY 2009 and 2008. If you use the IPF PPS PC PRICER 2008 or 2009, please go to *http://www.cms.hhs.gov/PCPricer/09_inppsy.asp*. Download the latest versions of the IPF PPS PC PRICER, which may be found under the Downloads section (posted May 15, 2009, and May 21, 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 200905-33

Revised inpatient psychiatric facility prospective payment system fact sheet

The *Inpatient Psychiatric Facility Prospective Payment System* fact sheet (revised May 2009), which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2010 update to the IPF PPS, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/InpatientPsychFac.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 200905-37

Update to the fiscal year 2009 inpatient prospective payment system PRICER

The inpatient prospective payment system (IPPS) personal computer (PC) PRICER for fiscal year (FY) 2009 required a coding correction for special pay transfer. The diagnosis-related group (DRG) 956 was removed from the special pay transfer list and moved to a regular post-acute care (PAC) transfer DRG. If you use the IPPS PC PRICER, go to *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, and download the FY 2009.6 version of the IPPS PC PRICER, updated May 28, 2009. ❖

Source: CMS PERL 200906-03

Revised disproportionate share hospital and critical access hospital fact sheets

The following revised publications are now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- **Medicare Disproportionate Share Hospital Fact Sheet (April 2009)** – provides information about methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005 provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH payment adjustment formulas, may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/2009_mdsh.pdf*.
- **Critical Access Hospital Fact Sheet (April 2009)** – provides information about eligible critical access hospital (CAH) providers, CAH designation, CAH payments, reasonable cost payment principles that do not apply to CAHs, election of standard payment or optional (elective) payment methods; Medicare rural pass-through funding for certain anesthesia services, health professional shortage area incentive payments, physician scarcity area bonus payments, Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact critical access hospitals, and grants to states under the Medicare Rural Hospital Flexibility program, may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/CritAccessHospfctsht.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 200906-11

Revised sole community hospital fact sheet

The revised *Sole Community Hospital* fact sheet (April 2009), which provides information about sole community hospital classification and payments, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/SoleCommHospfctsht508-09.pdf*. ❖

Source: CMS PERL 200906-25

Skilled Nursing Facility Services

Revised billing instructions for occurrence span code 74 for skilled nursing facility no-payment claims

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

Provider types affected

Skilled nursing facilities (SNFs) submitting no-payment claims (type of bill [TOB] 210) to Medicare contractors (fiscal intermediaries [FI] and Medicare administrative contractors [MAC]) for Medicare beneficiaries.

Provider action needed

This article informs SNFs that change request (CR) 6523 implements revised billing instructions for the use of occurrence span code 74 on SNF TOB 210. **As of October 5, 2009,** SNFs no longer need to use occurrence span code 74 in order for the bypass of no-pay TOB 210 on the Medicare system edits to occur. The Medicare systems will have been revised on that date and this temporary workaround is no longer necessary. SNFs should inform their billing staffs of this update.

Background

CR 6523 revises previous instructions indicated in CR 5583 that required SNFs to include occurrence span code 74 with the statement covers period of the 210 no pay bill they were submitting in order to allow 210 no pay bill types to process when overlapping previously paid 22x bill types. The previous instruction was a temporary workaround to allow the 210 no pay bill types to process without receiving Medicare system edits. Medicare systems changes have now been made so that SNFs no longer need to use occurrence span code 74 in order for the bypass of 210 no pay bills to occur.

Note: SNFs must continue to use the occurrence span code 74 to report the leave of absence from and through dates as indicated in the *Medicare Claims Processing Manual*, Chapter 6, Section 40.3.5.2 which is viewable on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf*.

Additional information

The official instruction 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/R1749CP.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*.

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Hospital Outpatient Prospective Payment System

July 2009 update of the hospital outpatient prospective payment system

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6492 which describes changes to and billing instructions for various payment policies implemented in the July 2009 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 6492 describes changes to and billing instructions for various payment policies implemented in the July 2009 OPPS update and it affects the *Medicare Claims Processing Manual* Chapter 1, Section 50.3; Chapter 4, Sections 10 and 290; and Chapter 17, Section 90.3. It also updates the Medicare *Benefits Policy Manual* (Chapter 6, Section 20.6) to clarify the existing policy.

July 2009 revisions to the integrated outpatient code editor (I/OCE) data files, instructions, and specifications are provided in CR 6480 (July 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.2)." Upon release of CR 6480 a related MLN Matters article will be available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6480.pdf*.

Key OPPS updates for July 2009

1. **Changes to procedure and device edits for July 2009**

   Procedure-to-device edits require that when a particular procedural Healthcare Common Procedure Coding System (HCPCS) code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits may be found under "Device, Radiolabeled Product, and Procedure Edits" on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

2. **Outlier reconciliation**

   CMS updated the *Medicare Claims Processing Manual* (Chapter 4, Section 10.7.2) to more explicitly identify distinctions between the OPPS outlier reconciliation policy and those of other payment systems. CMS made changes to note that the OPPS outlier reconciliation criteria use OPPS specific-information, specifically 1) the cost-to-charge ratio (CCR) is the OPPS CCR used to make OPPS outlier payments and 2) total outlier payments are total OPPS outlier payments. These changes clarify the manual language to eliminate confusion that the OPPS reconciliation might consider inpatient prospective payment system (IPPS) or other payment system CCRs or total outlier payments across payment systems.

3. **Updated PRICER logic for certain blood products**

   The January 2009 OPPS PRICER contained a programming error that may result in the underpayment or overpayment of certain blood products that are eligible for the blood deductible when billed together on the same claim. The whole blood and packed red cells described by the following HCPCS codes are eligible for the blood deductible:

HCPCS codes eligible for the blood deductible

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

The blood deductible is applied to these products only when the hospital incurs a charge for the blood product itself, in addition to a charge for processing and storage. The January 2009 OPPS PRICER programming error affects only those claims on which more than one of the blood product HCPCS codes listed above appears, when at least one of those codes is not subject to the blood deductible because the hospital did not incur a charge for the blood product itself.

Specifically, an underpayment or overpayment may occur when the following conditions are met:

1) More than one blood product that is eligible for the blood deductible (i.e., whole blood and packed red cells) appears on the claim.

2) At least one of the blood products appearing on the claim that is eligible for the blood deductible is not subject to the blood deductible due to the absence of payment adjustment flag (PAF) 5 and 6 indicating the hospital incurred a charge for the blood itself (the integrated outpatient code editor applies PAF 5 or 6 to blood lines eligible for the blood deductible when the hospital reports charges for the blood product itself using revenue code series 038x (excluding 0380) in addition to charges for processing and storage services using revenue code 0390, 0392, or 0399).

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

3) The dates of service fall on or after January 1, 2009, but prior to July 1, 2009.

4) The claim was processed for payment prior to the installation of the July 2009 OPPS PRICER on July 6, 2009.

This programming error has been corrected in the July 2009 OPPS PRICER. Providers who think they may have received an incorrect payment as a result of this programming error may voluntarily submit claims to their contractors for repayment following the implementation of the July 2009 OPPS PRICER on July 6, 2009.

4. Category III *CPT* codes

The American Medical Association (AMA) releases Category III *Current Procedural Terminology (CPT)* codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

As discussed in the calendar year (CY) 2006 OPPS final rule with comment period (70 FR 68567; see on the Internet *http://www.gpoaccess.gov/fr/retrieve.html*), CMS modified their process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III *CPT* codes and some of the C-codes that are payable under the OPPS and were created by us in response to applications for new technology services. Therefore, on July 1, 2009, CMS will implement in the OPPS four Category III *CPT* codes that the AMA released in January 2009 for implementation in July 2009. The codes, along with their status indicators and ambulatory payment classifications (APCs), are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2009 OPPS update that is posted on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

Table 1 – Category III *CPT* codes implemented as of July 1, 2009

CPT codes	Long Descriptor	APC	SI
0199T	*Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report*	0215	S
0200T	*Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles*	0049	T
0201T	*Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical devce (if utilized), two or more needles*	0050	T
0202T	*Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine*		C

5. Billing for drugs, biologicals, and radiopharmaceuticals

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

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned. Unless otherwise specified in the long description, HCPCS code descriptors refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPC does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

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

For CY 2009, payment for nonpass-through drugs and biologicals is made at a single rate of ASP plus four percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In CY 2009, a single payment of ASP plus six percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B drug competitive acquisition program (CAP) rate, as the CAP was suspended beginning January 1, 2009. Should the Part B drug CAP be reinstituted sometime during CY 2009, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP, as required by the statute.

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

In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2009 release of the OPPS PRICER. The updated payment rates, effective July 1 2009 will be included in the July 2009 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

b. **Drugs and biologicals with OPPS pass-through status effective July 1, 2009**
Nine drugs and biologicals have been granted OPPS pass-through status effective July 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and biologicals with OPPS pass-through status effective July 1, 2009

HCPCS code	Long descriptor	APC	Status indicator effective July 1, 2009
C9250*	Human plasma fibrin sealant, vapor-heated, solvent-detergent (artiss), 2ml	9250	G
C9251*	Injection, C1 esterase inhibitor (human), 10 units	9251	G
C9252*	Injection, plerixafor, 1 mg	9252	G
C9253*	Injection, temozolomide, 1 mg	9253	G
C9360*	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (surgimend collagen matrix), per 0.5 square centimeters	9360	G
C9361*	Collagen matrix nerve wrap (neuromend collagen nerve wrap), per 0.5 centimeter length	9361	G
C9362*	Porous purified collagen matrix bone void filler (integra mozaik osteoconductive scaffold strip), per 0.5 cc	9362	G
C9363*	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	9363	G
C9364*	Porcine implant, permacol, per square centimeter	9364	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2009.

c. **New HCPCS codes effective for certain drugs and biologicals**
Two new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting for July 2009. These codes are listed in Table 3 below and are effective for services furnished on or after July 1, 2009.

Table 3 – New HCPCS codes effective for certain drugs and biologicals effective July 1, 2009

HCPCS code	Long descriptor	APC	Status indicator effective July 1, 2009
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	1268	K
Q4116	Skin substitute, alloderm, per square centimeter	1270	K

d. **Updated payment rates for certain HCPCS codes effective January 1, 2009, through March 31, 2009**
The payment rates for several HCPCS codes were incorrect in the January 2009 OPPS PRICER. The corrected payment rates are listed in Table 4 below and have been installed in the July 2009 OPPS PRICER, effective for services furnished on January 1, 2009, through implementation of the April 2009 update. If you have claims that were processed prior to April 1, 2009, with these codes for services on or after January 1, 2009, but prior to April 1, 2009, you may ask your Medicare contractor to adjust the claims.

Table 4 – Updated payment rates for certain HCPCS codes effective January 1, 2009, through March 31, 2009

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J1441	K	7049	Filgrastim 480 mcg injection	$304.27	$60.85
J1740	K	9229	Ibandronate sodium injection	$136.35	$27.27
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,135.12	$427.02
J7513	K	1612	Daclizumab, parenteral	$341.09	$68.22

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

e. **Recognition of multiple HCPCS codes for drugs**
Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a status indicator "B" indicating that another code existed for OPPS purposes. For example, if drug X has two HCPCS codes, one for a 1 ml dose and a second for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and status indicator "B" to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPPS. However, beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

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

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

h. **Unit correction – HCPCS code J9181, etoposide, 10 mg**
Table 5 'HCPCS Code Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008' listed in Transmittal 1657, Change Request (CR) 6320, issued December 31, 2008, incorrectly listed the number of units in the long code descriptor for HCPCS code J9181, etoposide ,10 mg. HCPCS code J9181 which is assigned status indicator 'N' in CY 2009 under the OPPS, is the code for 10 mg of etoposide, while HCPCS code J9182 was discontinued effective January 1, 2009. Providers may review the short and long HCPCS code descriptors in the HCPCS file that is available on the CMS Web site at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/*.

6. **Clarification related to the appropriate use of HCPCS code C9399**
CMS revised the *Medicare Claims Processing Manual* (Chapter 17, Section 90.3) to clarify the appropriate use of HCPCS code C9399. Specifically, HCPCS code C9399 should be used by hospitals when billing a new drug or biological that has been approved by the FDA on or after January 1, 2004 and for which a product-specific HCPCS code has not been assigned. Beginning on or after the date of FDA-approval, hospitals may bill for the drug or biological using C9399, unclassified drug or biological. Hospitals will report in the ANSI ASC X-12 837 I in specific locations, or in the "Remarks" section of the UB-04 CMS-1450:

- The national drug code (NDC)
- The quantity of the drug that was administered (expressed in the unit of measure applicable to the drug or biological)
- The date the drug was furnished to the beneficiary.

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

Medicare contractors will manually price the drug or biological at 95 percent of the average wholesale price (AWP). They will pay hospitals 80 percent of the calculated price and will bill beneficiaries 20 percent of the calculated price, after the deductible is met. Drugs and biological that are manually priced at 95 percent of AWP are not eligible for outlier payment.

7. **Changes to Nuclear medicine procedure-to-radiolabeled product edits for July 2009**
   Nuclear medicine procedure-to-radiolabeled product edits require that when a nuclear medicine procedure HCPCS code is billed, the claim must also contain an appropriate radiolabeled product. Failure to pass these edits will result in the claim being returned to the provider. Nuclear medicine procedure-to-radiolabeled product edits require that a claim that contains one of a specified set of nuclear medicine codes be returned to the provider if it fails to contain an appropriate radiolabeled product code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

8. **Clarification related to observation services**
   CMS updated the *Medicare Claims Processing Manual* (Chapter 4, Section 290) and the *Medicare Benefit Policy Manual* (Chapter 6, Section 20.6) to clarify that a hospital begins billing for observation services, reported with HCPCS code G0378, at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services. Editorial changes to the manuals remove references to "admission" and "observation status" in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term "admission" is typically used to denote an inpatient admission and inpatient hospital services. For payment purposes, there is no payment status called "observation". Observation care is an outpatient service, ordered by a physician and reported with a HCPCS code.

9. **Clarification related to condition code 44**
   The changes to the *Medicare Claims Processing Manual* (Chapter 1, Section 50.3) incorporate information and guidance published in *MLN Matters* article SE0622, published March, 2006, which you may review on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf*.

   MLN Matters article SE0622 provided clarification to Transmittal 299, CR 3444, issued September 10, 2004. You may also review the revised Chapter 1 (Section 50.3) of the *Medicare Claims Processing Manual*, which is included as an attachment to CR 6492, which is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1760CP.pdf*.

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

Additional information

The official instruction, CR [6492], was issued to your FI, MAC, and RHHI in two transmittals. The first transmittal modifies the *Medicare Benefit Policy Manual* and is on the CMS Web site on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R107BP.pdf*.

The second transmittal modifies the *Medicare Claims Processing Manual* and it is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1760CP.pdf*.

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

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Electronic Data Interchange

Remittance advice remark code and claim adjustment reason code update

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

Provider types affected

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

Provider action needed

Change request (CR) 6453, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective July 1, 2009. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets are used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated three times a year (early March, July, and November) although the Committee meets every month.

The CARC list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes. The CARC list is also updated three times a year (early March, July, and November) along with the RARC list.

Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of the additional information section of this article summarize the latest changes to these lists, as announced in CR 6453.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at *http://www.cmsremarkcodes.info* on the Internet. Note that this Web site does not replace the Washington Publishing Company (WPC) site. That site is *http://www.wpc-edi.com/Codes* and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional information

As a reminder, CR 6336 noted that CARC 17 is being replaced with two new CARCs:

226 Information requested from the billing/rendering provider was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)

227 Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)

To see the official instruction (CR 6453) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.pdf*.

For additional information about remittance advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or 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*.

New codes – CARC

Code	Current narrative	Effective date per WPC posting
229	Partial charge amount not considered by Medicare due to the initial claim type of bill being 12X. Note: This code can only be used in the 837 transaction to convey coordination of benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use group code PR.	1/25/2009
230	No available or correlating *CPT*/HCPCS code to describe this service, Note: Used only by Property and Casualty	1/25/2009

Remittance advice remark code and claim adjustment reason code update (continued)

Modified codes – CARC

Code	Current narrative	Effective date per WPC posting
187	Health Savings account payments. This change to be effective 10/1/2009: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	1/25/2009

Deactivated codes – CARC

Code	Current narrative	Effective date
17	Requested information was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	7/1/2009
156	Flexible spending account payments. **Note:** Use code 187.	10/1/2009

New codes – RARC

Code	Current narrative	Medicare initiated
N516	Records indicate a mismatch between the submitted NPI and EIN.	No
N517	Resubmit a new claim with the requested information	Yes
N518	No separate payment for accessories when furnished for use with oxygen equipment.	Yes

Modified codes – RARC

Code	Current narrative	Medicare initiated
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Start: 01/01/1997 Last Modified: 03/01/2009 Notes: (Modified 4/1/07. 3/1/2009)	Yes
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records. Start: 02/28/2002	Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	Yes
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 04/01/2007	Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	Yes

Deactivated codes – RARC

Code	Current narrative	Medicare initiated
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead) Start: 11/01/2008	Stop: 10/01/2009	Yes

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Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1734, CR 6453

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Fraud and Abuse

The Medicare-Medicaid data matching project

In 2003, the Centers for Medicare & Medicaid Services (CMS) initiated a project with the state of Florida designed to share and analyze both Medicare and Medicaid data to better coordinate benefit integrity efforts between the two programs. Now known as Medi-Medi, claim data from both programs is analyzed together to detect patterns that may not be evident when billings for either program are viewed in isolation. As a result of combining the data, previously undetected patterns may be identified, such as "time bandits"; that is, providers who bill for a total of more than 24 hours in a day to both programs. This project allows vulnerabilities in both programs to be identified, and where appropriate, actions can be taken to protect the federal share of Medicaid and Medicare dollars.

First piloted in California in 2001, Medi-Medi is being expanded nationally with the enactment of the Deficit Reduction Act of 2005. In all of the projects, federal and state law enforcement and program integrity partners work together to identify fraudulent behaviors.

Since 2005, the Florida Medi-Medi project has generated 38 investigations with over $57 million in overpayments associated with those investigations. A recent project, which matched hospice-claim data between the two programs, uncovered the following activity:

> Analysis was conducted on claims for hospice services furnished to dually eligible Medicare and Medicaid recipients. Over $1.8 million was identified in duplicate payments for 262 dually-eligible recipients; that is, both Medicare and Medicaid each paid for the same services as a primary payer where Medicare should have been the primary payer. The state overpaid hospice providers who submitted the duplicate claims and is recovering the over $1.8 million in overpayments. Without the data matching, the overpayments would not have been identified nor recovered.

These are the types of patterns that a project like Medi-Medi, which shares and compares billings from both programs, is uniquely designed to discover. All Medi-Medi projects conduct analyses to determine if, and to what extent, vulnerabilities, fraudulent activities, and/or overpayments may exist.

SafeGuard Services LLC is the zone program integrity contractor (ZPIC) for Florida, Puerto Rico, and the U.S. Virgin Islands. The ZPIC is responsible for identifying and investigating health care fraud for the Medicare program. Its scope of work also includes the Florida Medi-Medi Data Matching Project in collaboration with the Agency for Health Care Administration's (AHCA) Office of Inspector General/Medicaid Program Integrity (IOG/MPI) and the Medicaid Fraud Control Unit.

Source: Information provided by SafeGuard Services, ZPIC for Florida, Puerto Rico, and the U.S. Virgin Islands

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Educational Events

Upcoming provider outreach and educational events

July 2009 – September 2009

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

Hot Topic Series – Medicare 2009 updates and changes

When: Tuesday, July 21, 2009

Time: 2:00 p.m. – 3:30 p.m. ET **Delivery language:** Spanish

Type of Event: Webcast **Focus:** Puerto Rico

Topic – Medifest educational event – Orlando, Florida

When: Tuesday and Wednesday, September 1 and 2, 2009

Time: 8:00 a.m. – 5:00 p.m. ET **Delivery language:** English

Type of Event: In person seminar/symposium **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Hot Topic Series – Medicare 2009 updates and changes

When: Wednesday, September 16, 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

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. ❖

Medifest 2009 – face-to-face symposium in Orlando, FL

When: Tuesday, September 1 and Wednesday, September 2

Where: Renaissance Orlando Hotel Airport
5445 Forbes Place
Orlando, FL 32812
(407) 240-1000
http://www.marriott.com/hotels/travel/mcora-renaissance-orlando-hotel-airport/

Time: 8:00 a.m. – 5:00 p.m.

Delivery language: English

Join us for First Coast Service Options (FCSO) exciting Medicare educational event: Medifest 2009. This dynamic, face-to-face symposium will be held in Orlando, Florida and is open to all members of FCSO's provider community. Take advantage of Medicare educational workshops, learning from FCSO's Medicare experts, and talk with representatives from companies offering products and services especially designed for Medicare providers.

You may attend one or both days, and each day will feature a wide selection of informative seminars and workshops designed to help you increase your knowledge of Medicare and facilitate your continued success as a Medicare provider.

You may now access our Web site for the event's agenda, individual course descriptors, and registration instructions and tools.

Here's a sneak preview of Medifest 2009:

- Part A and Part B workshop topics will be selected based upon analysis of current data, including the types of inquiries received in our provider contact center, the types of claim submission errors most frequently experienced by members of our provider community, and prepayment/postpayment medical review activity.
- Each informative workshop will feature live demonstrations and real-life scenarios (whenever possible). In addition, you'll have the opportunity to interact with your peers and Medicare experts from across the FCSO organization, engage in the learning and problem-solving process, and learn how to take advantage of the wealth of Medicare resources available on the Centers for Medicare & Medicaid (CMS) as well as the FCSO Medicare provider Web sites.
- To ensure that participants can take advantage of the intermediate and advanced-level Medicare workshops, we'll identify special FCSO Medicare educational webcasts and Web-based training (WBT) modules (offered prior to the event) to help less experienced providers acquire a solid foundation of knowledge as well as a basic understanding of the Medicare program.
- You'll have the opportunity to preview products and services designed especially for Medicare providers, including billing and practice management software and tools, and talk with the representatives of the companies that offer them.

Check our new Medifest page (*http://medicare.fcso.com/Medifest/*) regularly for the latest information on the following topics:

- Agenda
- Course descriptions
- Hotel information
- Registration instructions
- Vendor information

This will be the only Medifest event for Florida, Puerto Rico and the U.S. Virgin Island providers in 2009 so don't forget to mark your calendars.

Stay informed: Subscribe to eNews

If you would like to be among the first to learn the latest news and information about Medifest 2009 and the Medicare program, subscribe to eNews, our free electronic mailing service. To sign-up for eNews, click the "Join eNews" button located in the top-right corner of our Web site *http://medicare.fcso.com.* And don't forget to mark your calendar for this exciting event . . . we'll see you there. ❖

Preventive Services

June 7 is National Cancer Survivors Day

In honor of the millions of Americans who are living with a history of cancer, the Centers for Medicare & Medicaid Services (CMS) reminds the Medicare provider community of the many cancer screenings that Medicare covers. Early detection and treatment of cancer can help Medicare patients live longer, healthier lives.

What can you do?

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients who may be at risk for cancer by educating them about their risk factors and reminding them of the importance of getting the preventive cancer screenings covered by Medicare.

For more information

CMS has developed several educational products related to Medicare-covered preventive services, including screenings for various forms of cancer. Please visit the *Medicare Learning Network* for more information, including the following cancer-screening pages:

- **The *MLN* Preventive Services Educational Products Web Page** – provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- **Cancer Screenings Brochure** – this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of cancer screening tests, including screening mammographies, screening pap tests, screening pelvic exams, colorectal screenings, and prostate cancer screenings: *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.
- **Quick Reference Information: Medicare Preventive Services** – this double-sided chart provides coverage and coding information on Medicare-covered cancer screenings: *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

Thank you for helping CMS improve the health of Medicare beneficiaries who are at risk for cancer by joining in the effort to educate beneficiaries about cancer, and the importance of early detection by taking advantage of the cancer screenings covered by Medicare. ❖

Source: CMS PERL 200906-10

June 15-21 is National Men's Health Week and June 21 is Father's Day

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep men with Medicare healthy by ensuring that they take advantage of Medicare-covered preventive services. Medicare covers colorectal and prostate cancer screenings, among other preventive services.

What can you do?

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients who may be at risk for cancer by educating them about their risk factors and reminding them of the importance of getting the preventive cancer screenings covered by Medicare. Early detection and treatment of cancer may help men with Medicare live longer, fuller, healthier lives.

For more information

CMS has developed several educational products related to Medicare-covered preventive services, including screenings for various forms of cancer. Please visit the *Medicare Learning Network* (*MLN*) for more information, including the following cancer-screening pages:

- **The *MLN* Preventive Services Educational Products Web Page** – provides descriptions and ordering information for *MLN* preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
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- **Quick Reference Information: Medicare Preventive Services** – this double-sided chart provides coverage and coding information on Medicare-covered cancer screenings. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

Thank you for helping CMS improve the health of men with Medicare who are at risk for cancer by joining the effort to educate beneficiaries about cancer, and the importance of early detection by taking advantage of the cancer screenings covered by Medicare. ❖

Source: CMS PERL 200906-23

Other Educational Resources

Revised Web-based training course for certificate of medical necessity

The Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (*MLN*) has made available a course that contains information about the certificate of medical necessity, most commonly known as a CMN.

This course will be helpful to physicians, health care professional, and medical administrative staff in the completion, submission and maintenance of the documentation required to verify the CMN, available at *http://www.cms.hhs.gov/MLNGenInfo*. Scroll to the *Related Links Inside CMS* section at the bottom of the page. Locate and select *Certificate of Medical Necessity WBT* from the list provided. Upon completion of this course you should be able to:

- List the items that require a CMN
- Identify the responsibilities of physicians, physician assistants, nurse practitioners, or clinical nurse specialists as they relate to the CMN
- Define medical record documentation
- Identify the sections of a CMN
- List CMN common errors
- Identify CMN completion resources

Successful completion of this course requires completion of all course lessons, pre-test, course evaluation and a score of 70 percent of higher on the post-test. The CMS is authorized by IACET to offer 0.1 continuing education units (CEUs) for this program.

CMS designates this educational activity for a maximum of one AMA PRA category one credit(s) TM. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Credit for this course expires May 4, 2012.

This course and its post test score of 70 percent or higher, are approved for one CEU by the American Academy of Professional Coders (AAPC). Index # CMS06140728A

When submitting a CMS completed Web-based training course to AAPC as part of your recertification, please retain a copy of your CMS certificate and a copy of the course description that contains the AAPC index number and number of AAPC CEUs. The AAPC will request copies of these if you are selected for verification of the CEUs listed on your renewal form.

The author has no conflicts of interest to disclose.

This course was developed without any commercial support.

The Web site to view the biographical information of the course developers is available at *http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/2009_May_Biographical_Data_CMN_WBT.pdf*. ❖

Source: CMS PERL 200906-26

Revised rural referral center fact sheet

The revised *Rural Referral Center fact sheet* (April 2009), which provides information about rural referral center program requirements, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralRefCtrfctsht2008.pdf*. ❖

Source: CMS PERL 200906-28

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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). Nonprovider 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***)	$	
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Mail this form with payment to:

First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name:

Provider/Office Name:

Telephone Number (include area code):

Mailing Address:

City:

State, ZIP Code:

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ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

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

MEDICARE SECONDARY PAYER
Information on Hospital Protocols
Admission Questionnaires, Audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

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

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

ELECTRONIC CLAIM FILING
Direct Data Entry (DDE) Startup
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

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First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

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Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and SNF Routine Cost Limit Exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

PROVIDER ENROLLMENT
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

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American Diabetes Association Certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

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532 Riverside Av.
Jacksonville, FL 32202-4914

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REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
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
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS
Customer Service Center Toll-Free
1-888-664-4112

Interactive voice response (IVR)
1-888-664-4112

Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY
Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

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Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

CREDIT BALANCE REPORT
Debt Recovery
1-904-791-6281
Fax
1-9043610359

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PROVIDERS
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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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♦ ATTENTION BILLING MANAGER ♦