MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Unsolicited/voluntary refunds
Medicare reminds providers of the rights of the federal goverment, and its agencies on this important regulation 5

Annual clotting factor furnishing fee schedules
Announcement of the 2010 furnished fee of $0.170 per international unit 19

FDG PET for solid tumors and myeloma
Revision to the national coverage determination for this service 21

Billing for wrong surgery on a patient
Clarification on the use of appending the correct modifier when billing for this service 25

Local coverage determinations
Revisions to existing LCDs coverage guidelines 27

Coverage of inpatient rehabilitation services
Existing Medicare contractors local coverage determinations for these services are no longer effective with discharge occurring on or after January 1, 2010 34

End-stage renal disease services
Announcement of the fistula first-breakthrough initiative strategic plan 58

Skilled nursing facility services
Correct billing changes affecting the payment rate ordering for a limited number of residents 59

CORF/ORF services
Guidelines have been ammended to clarify general requirements, covered and noncovered services, and provisions of services 62

Features

About this Bulletin 3
General Information 4
General Coverage 19
Local Coverage Determinations 27
Hospital Services 34
End-Stage Renal Disease 58
SKilled Nursing Facility Services 59
CORF/ORF Services 62
Electronic Data Interchange 66
Educational Resources 70

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

Table of Contents

In This Issue 1

About this Bulletin
About the *Medicare A Bulletin* 3
Quarterly Provider Update 3

General Information
Timely claim filing guidelines for all Medicare providers 4
New United States pharmacopeia standards for heparin products will result in decreased potency 4
Updates to physician payment information for value-driven health care 4
Unsolicited/voluntary refunds 5
October 2009 average sales price file is now available 5
Download chart on how to access CMS enterprise applications 5
Revised ICD-10-CM/PCS: An Introduction fact sheet 5
Protect your patients and yourself from influenza and get vaccinated 5
2009-2010 seasonal influenza resources for health care professionals 6
Flu season is upon us 8
Ensuring only clinical trial services receive fee-for-service payment on claims billed for managed care beneficiaries 9
Information about the DMEPOS competitive bidding program – round one rebid 10
Revised processing of osteoporosis drugs under the home health benefit 12

Ambulance Services
Billing ambulance transport with more than one patient onboard 13

Electronic Health Records
Health information technology news – a message from Dr. Blumenthal 14

Claim and Inquiry Summary Data
Top inquiries, return to provider, and reject claims for September 2009 16

General Coverage
Annual clotting factor furnishing fee update 19
Magnetic resonance imaging 20
FDG positron emission tomography for solid tumors and myeloma 21
Clarification of the use of modifiers when billing wrong surgery on a patient 25
Influenza vaccine payment allowances – annual update for 2009-2010 season 26

Local Coverage Determinations
LCD table of contents 27

Hospital Services
Coverage of inpatient rehabilitation services 34
Revised October 2009 quarterly provider specific file update 39
Hospital outpatient department payment information for value-driven health care 39
Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes 40
Rural floor budget neutrality factors for acute care hospitals – Fiscal year 2010 48
Section 505 adjustment: Provider numbers and corresponding special wage indexes 49
Hospital quality initiative 51
Wage-index changes 54
Wrong surgical/other invasive procedure performed on a patient and/or body part 55

ESRD Services
Fistula first breakthrough initiative provides roadmap to reach 66 percent goal 58

SNF Services
Reminder about correct billing changes for certain skilled nursing facility residents 59
Five-star quality rating system 61

CORF/ORF Services
Comprehensive outpatient rehabilitation facility coverage 62

Electronic Data Interchange
Update of remittance advice remark codes and claim adjustment reason codes 66
Activation of new COB agreement trading partner dispute error code 68

Educational Resources
Educational Events
Upcoming POE events 70

Preventive Services
October is Healthy Lung Month 71

Other Educational Resources
Revised rural health publications 72
Revised Medicare Learning Network publications 72
Message from the Medicare Learning Network 73

Order form for Medicare Part A materials 74

Important Addresses, Phone Numbers and Web sites – Florida 75
Important Addresses, Phone Numbers and Web sites – U.S.Virgin Islands 76

Medicare A Bulletin

Vol. 11, No. 10
October 2009

Publication Staff

Millie C. Pérez
Terri Drury
Mark Willett
Robert Petty

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

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

Medicare Publications
1-904-361-0723

About the *Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Medicare Part A providers in Florida, 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

Timely claim filing guidelines for all Medicare providers

Medicare regulations establish a time limit for submitting claims to the contractor within the established timeliness parameters. In general, such claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is the second year after the year in which such services were furnished. Based on this regulation, providers have a minimum of 15 months to a maximum of 27 months.

The time parameters are:

Dates of Service	Last Filing Date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011
October 1, 2010 – September 30, 2011	by December 31, 2012

Periodic interim payment (PIP) providers must submit claims by the last day of the year following the year of the discharge date.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to the provider (RTP) for correction, is not protected from the timely filing guidelines.

Medicare determines whether a claim has been filed timely by comparing the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is received. If the span between these two dates exceeds the time limitation, the claim is considered to have been not timely filed. When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination". As such, the determination that a claim was not filed timely is not subject to appeal. ❖

Source: CMS Pub. 100-04 (*Medicare Claim Processing Manual*), Chapter 1, Section 70

New United States pharmacopeia standards for heparin products will result in decreased potency

For the Centers for Medicare & Medicaid Services providers and interested health care advocates

To ensure the quality of heparin and to guard against potential contamination, the United States pharmacopeia (USP), a nonprofit standard-setting organization, adopted new manufacturing controls for heparin effective October 1, 2009. These changes include a modification of the reference standard for the drug's unit dose resulting in a 10 percent reduction in potency. A link to a U.S. Food and Drug Administration (FDA)-health alert is provided in the FDA press release (link provided below).

While there are concerns that quantities of the former dosage may linger for some months, it is important to share this update with health care providers, advocacy groups, and others. The FDA news release is available at *http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm184674.htm*. ❖

Source: CMS PERL 200910-03

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Updates to physician payment information for value-driven health care

To support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions, the U.S. Department of Health & Human Services is making cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2007 and 2008 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

The hospital information is posted on the Hospital Compare Web page where it may be viewed along with hospital quality information at *http://www.medicare.gov*.

On August 28, 2009, Medicare posted an update to the ASC data. The physician payment data was posted on September 25, 2009. Hospital outpatient department data will be updated later this year. The information is being displayed in the same format as in previous years, updated with calendar year 2008 data. The posting updates may be found at *http://www.cms.hhs.gov/HealthCareConInit/*. ❖

Source: CMS PERL 200909-38

Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

> The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims. ❖

Source: CMS Pub. 100-06, Transmittal 50, CR 3274

October 2009 average sales price file is now available

The Centers for Medicare & Medicaid Services has posted the revised October 2009 average sales price (ASP) and not otherwise classified (NOC) pricing files, which are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp*. ❖

Source: CMS PERL 200910-07

Download chart on how to access CMS enterprise applications

The revised quick reference chart, *Steps to Accessing CMS Enterprise Applications for Provider Organizations* (August 2009), is now available for download. This chart for provider organizations outlines how to access the Centers for Medicare & Medicaid Services (CMS) enterprise applications. CMS enterprise applications are those hosted and managed by CMS and do not include fiscal intermediary/carrier/Medicare administrative contractor (MAC) Internet applications.

You may access this product on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSChart.pdf*. ❖

Source: CMS PERL 200909-28

Revised ICD-10-CM/PCS: An Introduction fact sheet

The revised fact sheet titled *ICD-10-CM/PCS: An Introduction* (August 2009) provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations. The revised publication is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*.

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

Note: If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200909-35

Protect your patients and yourself from influenza and get vaccinated

The Centers for Disease Control and Prevention recommends seasonal and 2009 monovalent H1N1 influenza vaccination for all health care workers because of their critical role in the health care system and their increased risk of exposure to patients with influenza, as well as concern about transmission of the viruses to susceptible patients.

The 2009 H1N1 monovalent influenza vaccine is made in the same way as seasonal flu vaccine, which has a very good safety track record. Preliminary data suggest that the immunogenicity and safety of these vaccines are similar to those of seasonal influenza vaccines.

Seasonal influenza vaccination among healthcare personnel reduces the flu-related mortality risk among patients at highest risk of severe illness. Despite the documented benefits of healthcare worker vaccination, seasonal influenza vaccine coverage in past seasons among this group has remained low (<50 percent) nationwide.

Influenza outbreaks in hospitals and long-term care facilities have been associated with low vaccination rates among healthcare workers, while higher vaccination levels among staff are associated with a lower incidence of nosocomial influenza cases.

More information on locating 2009 monovalent H1N1 and seasonal vaccine, priority groups for vaccination, and vaccine safety is located at *http://www.flu.gov*.

The most effective way to protect yourself and your patients from flu is to be vaccinated. It's up to you! ❖

Source: CMS PERL 200910-28

2009-2010 seasonal influenza resources for health care professionals

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

Provider types affected

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who bill Medicare for seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider action needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2009-2010 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction

Historically, the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu and pneumococcal immunizations. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Prevention is key to public health

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, this year, due to planning for H1N1 flu, Medicare will make payment for seasonal flu vaccines that are provided earlier in the year than usual.

Seasonal flu vaccines can still help protect Medicare beneficiaries who get the vaccine in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

1. *MLN Matters* seasonal influenza articles

MM6608: Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6608.pdf*.

MM6539: 2009 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6539.pdf*.

MM5511: Update to *Medicare Claims Processing Manual*, Chapter 18, Section 10 for Part B Influenza Billing on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf*.

MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf*.

MM5037*:* Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (*CPT*) Code *90660* for the Reporting of the Influenza Virus Vaccine on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf*.

2. MLN Seasonal Influenza Related Products for Health Care Professionals

Quick Reference Information: Medicare Part B Immunization Billing – This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick

2009-2010 seasonal influenza resources for health care professionals (continued)

information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is available in print and as a downloadable PDF on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Third Edition – This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. The guide is available as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.

Medicare Preventive Services Adult Immunizations Brochure – This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. This brochure is available as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.

Quick Reference Information: Medicare Preventive Services – This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/ coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. This chart is available in print or as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

Medicare Preventive Services Bookmark – This bookmark lists the preventive services and screenings covered by Medicare (including seasonal influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. This bookmark is available in print or as a downloadable PDF file on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf*.

***MLN* Preventive Services Educational Products Web Page** – This Medicare Learning Network (MLN) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals.
PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page for easy access (*http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*).

3. Other CMS resources

- **CMS Adult Immunizations Web Page** is on the CMS Web site at *http://www.cms.hhs.gov/AdultImmunizations*.
- **CMS Frequently Asked Questions** are available on the CMS Web site at *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi*.
- ***Medicare Benefit Policy Manual*** - Chapter 15, Section 50.4.4.2 – Immunizations available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf*.
- ***Medicare Claims Processing Manual*** – Chapter 18, Preventive and Screening Services available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf* .
- **Medicare Part B Drug average sales price payment amounts, influenza and pneumococcal vaccines pricing** found on the CMS Web site at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp*.

4. Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009 – 2010 flu season:

- **Advisory Committee on Immunization Practices** are on the Internet at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- **American Lung Association's Influenza (Flu) Center** is at *http://www.lungusa.org* on the Internet. This Web site provides a flu clinic locator on the Internet at *http://www.flucliniclocator.org*.

Individuals can enter their ZIP code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.

2009-2010 seasonal influenza resources for health care professionals (continued)

Other sites with helpful information

- **Centers for Disease Control and Prevention** – *http://www.cdc.gov/flu*
- **Flu.gov** – *http://www.flu.gov*
- **Food and Drug Administration** – *http://www.fda.gov*
- **Immunization Action Coalition** – *http://www.immunize.org*
- **Immunization: Supporting a Healthy Life Throughout the Lifespan** – *http://www.nfid.org/pdf/publications/naiaw08.pdf*
- **Indian Health Services** – *http://www.ihs.gov/*
- **National Alliance for Hispanic Health** – *http://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** – *http://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** – *http://www.nlm.nih.gov/medlineplus/immunization.html*
- **National Network for Immunization Information** – *http:/www.immunizationinfo.org*
- **National Vaccine Program** – *http://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Promotion** – *http://odphp.osophs.dhhs.gov*
- **Partnership for Prevention** – *http://www.prevent.org*
- **World Health Organization** – *http://www.who.int/en* on the Internet

Beneficiary information

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

Important information about H1N1

Medicare will cover immunizations for H1N1 influenza, also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the Fall 2009. For more information, go to the CMS Web site *http://www.cms.hhs.gov/H1N1*.

MLN Matters® Number: SE0926
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 SE0926

Flu season is upon us

The Centers for Medicare and Medicaid Services (CMS) encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get seasonal flu shots. Flu shots are their best defense for combating flu this season. And don't forget, health care workers also need to protect themselves.

Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient as a Part B benefit. No deductible or copayment/coinsurance applies. Note that influenza vaccine is not a Part D covered drug. For more information about Medicare's coverage of the seasonal influenza vaccine and its administration, as well as related educational resources for health care professionals, please go to the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

For information on Medicare policies related to H1N1 influenza, please go to the CMS Web site at *http://www.cms.hhs.gov/H1N1*. ❖

Source: CMS PERL 200910-07

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

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6455 to include the note at the end of the "Provider action needed" section. All other information remains the same. The *MLN Matters* article MM6455 was published in the May 2009 *Medicare A Bulletin* (page 10).

Provider types affected

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

Provider action needed

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

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

Note: Providers who are not required to report HCPCS codes, or for revenue codes that do not require a HCPCS code, providers shall report a not otherwise classified (NOC) code when reporting lines related to the clinical trial for a managed care beneficiary. By doing so, the provider is able to report the appropriate clinical trial HCPCS modifier (Q0 or Q1) for the NOC line.

Background

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

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

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

Medicare summary notice

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

Claim adjustment reason code

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

Group code

CO – Contractual obligation

Additional information

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

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

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

Source: CMS Pub. 100-04, Transmittal 1723, CR 6455

Information about the DMEPOS competitive bidding program – round one rebid

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

Provider types affected

This article is for all suppliers that furnish Medicare Part B durable medical equipment, prosthetic devices, prosthetic or orthotic items and supplies (DMEPOS) to Medicare beneficiaries. Critical changes are coming that will affect the way Medicare pays for DMEPOS and how Medicare determines who can bill for DMEPOS. This article provides important reminders about some of these changes, which will be occurring in the very near future and how these changes affect suppliers who will participate in the DMEPOS competitive bidding program.

Suppliers are urged to review this article and be sure they are prepared for these changes in order to continue providing DMEPOS to Medicare patients.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) reminds DMEPOS suppliers enrolled with the national supplier clearinghouse (NSC) they are required to obtain accreditation by October 1, 2009, unless exempt, and obtain a surety bond by October 2, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

Caution – what you need to know

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. Voluntary termination allows you to re enroll once you meet the requirements to participate in the Medicare program. If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Go – what you need to do

Whether or not you plan to remain as a Medicare supplier, it is recommended that you review this information. Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

Background

This article includes important reminder information for suppliers who will continue to serve as suppliers for Medicare beneficiaries on and after October 1, 2009.

Voluntary and non-voluntary terminations/ enrollment

Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009, and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntarily terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the NSC. By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

Accreditation

In a previous *MLN Matters*® article, SE0903, CMS informed suppliers of the importance of accreditation and the consequences of not being accredited on or before September 30, 2009. That article is on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf*.

If you have already been notified by an approved accrediting organization that each of your practice locations has been accredited, the accreditation organization will notify the NSC that your DMEPOS supplier practice locations have been accredited. However, DMEPOS suppliers who obtained accreditation after September 1, 2009, but before October 1, 2009, should submit proof of accreditation to the NSC via submission of an amendment to their CMS-855S.

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 on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Accreditation and DMEPOS Competitive Bidding

Suppliers choosing to participate in the DMEPOS Competitive Bidding Program must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

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

Information about the DMEPOS competitive bidding program – round one rebid (continued)

the applicable state licenses on file with the NSC. As part of the bid evaluation, CMS will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get accredited: Medicare DMEPOS suppliers, unless exempt, must be accredited by October 1, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

Get bonded: Medicare DMEPOS suppliers, unless exempt, must obtain and submit a surety bond by October 2, 2009. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of surety companies from which a bond can 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* on the Internet. When submitting your DMEPOS surety bond to the NSC, you are required to submit sections 1, 2A1, 12, and either 15 (if you are the authorized officials [AO] or 16 (if you are the delegated official) of the CMS-855S. By submitting the required sections of the CMS-855S, you will help to ensure that NSC is able to correctly associate your DMEPOS surety bond to your enrollment record.

Accessing the processes for the round one rebid

On August 3, 2009, CMS issued the bidding timeline for the round one rebid of the DMEPOS Competitive Bidding Program and initiated a comprehensive bidder education campaign. The CMS contractor, CBIC, is the focal point for bidder education. Please visit the CBIC dedicated Web site, *http://www.dmecompetitivebid.com/*, for important information, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC toll-free help desk, 1-877-577-5331, is open to help bidders with all of their questions and concerns. All suppliers interested in bidding are urged to sign up for e-mail updates on the home page of the CBIC Web site. The round one rebid will result in significant changes in the way Medicare pays for certain types of DMEPOS and it is critical that suppliers understand the process and what it takes to be eligible to bid.

In prior communications, CMS has described the processes for registering to use CMS systems. (See the *MLN Matters*® article, SE0915, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf* on the CMS Web site.) For the round one rebid, it is imperative that suppliers register so they will be able to participate in the bidding process for the categories of DMEPOS to be obtained only through the competitive bidding program.

Round one rebid registration milestones

Suppliers should be well into, if not completely through, this registration process. Registering now allows the AO and/or backup authorized official (BAO) time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with NSC. CMS recommends that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. (ET)–no AOs, BAOs, or EUs can register after registration closes. The legal name, date of birth, and social security number (SSN) of the AO and BAOs must match what is on file with the NSC in order to register successfully. To register, go to *http://www.dmecompetitivebid.com/* on the Competitive Bidding Implementation Contractor (CBIC) Web site.

If you have not started this process, please review the *Individuals Authorized Access to the CMS Computer Services (IACS) Reference Guide* at *http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/IACS_Reference_Guide.pdf/$FIle/IACS_Reference_Guide.pdf?Open&cat=Suppliers* for step-by-step instructions on registration.

The CBIC Web site also has the following useful tools:

- A registration checklist
- Quick step guides; and frequently asked questions
- All suppliers interested in bidding are urged to sign up for e-mail updates on the home page of the CBIC Web site. If you have any questions about the registration process, please contact the CBIC customer service center at 1-877-577-5331.

The target deadline for AOs interested in participating in the round one rebid to register was September 14, 2009. If you are an AO who has not yet registered – do it **today**! Visit *http://www.dmecompetitivebid.com/* to register.

Additional information

For more information on the DMEPOS competitive bidding program, visit the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/*.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Frequently asked questions (FAQs) on the surety bond requirement can be found on the NSC's FAQ page on the Internet at *http://www.palmettogba.com/nsc*.

MLN Matters® Number: SE0925
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 SE0925

Revised processing of osteoporosis drugs under the home health benefit

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 MM6512 to reflect revisions made to change request (CR) 6512. The CR release date, transmittal number, and the Web address for accessing CR 6512 were revised. All other information remains the same. The *MLN Matters* article MM6455 was published in the August 2009 *Medicare A Bulletin* (page 23).

Provider types affected

Home health agencies (HHA) submitting claims to Medicare contractors (regional home health intermediaries (RHHI), fiscal intermediaries (FI) and Medicare administrative contractors (MAC)) for injectable osteoporosis drugs provided to Medicare beneficiaries are affected.

Provider action needed

HHAs are reminded that the current criteria for coverage of injectable osteoporosis drugs must be met when submitting claims for these drugs. There is no change in these criteria. However, this article explains that the date of service on claims submitted for covered osteoporosis drugs must fall within the start and end dates of an existing home health prospective payment system (PPS) episode. Please inform your billing staffs of this requirement.

Background

Medicare covers injectable osteoporosis drugs if certain criteria are met. These criteria include:

- Eligibility for coverage of home health services
- Physician certification that the individual sustained a bone fracture related to post-menopausal osteoporosis
- Physician certification that the female patient is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Currently, the second and third criteria are enforced to the extent possible through Medicare systems by edits that require that the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present. However, the first criterion that the beneficiary must be covered under the home health benefit is only partially enforced. If an osteoporosis claim is received and a home health episode of care is on file, Medicare requires that the provider number of the HHA submitting the osteoporosis claim must be the same as the provider number on the episode record. CR 6512 revises the Medicare systems to fully enforce this criterion by requiring that the date of service for an injectable osteoporosis drug on a home health claim falls within the start and end dates of an existing home health episode if the claim contains:

- Type of bill 34x
- Healthcare Common Procedure Coding Systems (HCPCS) codes J0630, J3110 or J3490
- Covered charges corresponding to these HCPCS codes.

Claims not meeting the criteria for coverage will be rejected with the following messages: MSN message 6.5, "Medicare cannot pay for this injection because one or more requirements for coverage were not met," and claim adjustment reason code 177, "Patient has not met the required eligibility requirements."

Additional information

The official instruction, CR 6512, issued to your Medicare RHHI, FI, and/or MAC regarding this change, may be viewed at on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1818CP.pdf*.

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

MLN Matters® Number: MM6512 –Revised
Related Change Request (CR) Number: 6512
Related CR Release Date: September 18, 2009
Effective Date: January 1, 2010
Related CR Transmittal Number: R1818CP
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1818, CR 6512

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

AMBULANCE SERVICES

Billing ambulance transport with more than one patient onboard

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, fiscal intermediaries [FI], and A/B Medicare administrative contractors [A/B MAC]) for ambulance services provided to Medicare beneficiaries, are affected.

Provider action needed

This article advises ambulance suppliers that change request (CR) 6621 communicates claims processing instructions for ambulance service claims submitted for trips with more than one patient onboard. These changes are to be added to the Ambulance chapter of the *Medicare Claims Processing Manual* (Chapter 15). Please inform your billing staffs of these changes.

Background

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR 6621 to highlight changes that are to be made to the *Medicare Claims Processing Manual*, Chapter 15, Ambulance Services. This article is informational in nature, since CR 6621 revises that manual to incorporate information previously released via transmittal B-02-060, CR1945, "Payment Policy When More Than One Patient is Onboard an Ambulance" on September 27, 2002, and Transmittal A-02-108, CR 2186, "Multiple Patient Ambulance Transport" on October 25, 2002.

These changes to the *Medicare Claims Processing Manual* are:

- Ambulance suppliers submitting a claim using the CMS-1500, or the electronic equivalent ANSI X12N 837, for an ambulance transport with more than one Medicare beneficiary onboard must use the modifier GM (multiple patient on one ambulance trip) for each service line item. In addition, suppliers are required to submit to B/MACs/carriers documentation to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim (HIC) numbers for each Medicare beneficiary. B/MACs/carriers shall calculate payment amounts based on policy instructions found in the *Medicare Benefit Policy Manual*, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.
- For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

Additional information

The official instruction, CR 6621, issued to your Medicare contractor regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1821CP.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: MM6621
Related Change Request (CR) Number: 6621
Related CR Release Date: September 25, 2009
Related CR Transmittal Number: R1821CP
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

Source: CMS Pub. 100-04, Transmittal 1821, CR 6621

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

ELECTRONIC HEALTH RECORDS

Health information technology news – a message from Dr. Blumenthal

The Office of the National Coordinator for Health Information Technology (ONC) has distributed this message through their communication channels and posted it on their Web site at the following link *http://healthit.hhs.gov/portal/server.pt?open=512&objID=1350&parentname=CommunityPage&parentid=5&mode=2&in_hi_userid=11113&cached=*.

"Meaningful" Progress toward Electronic Health Information Exchange

A message from Dr. David Blumenthal, National Coordinator for Health Information Technology

I recently reported on our announcement of State Health Information Technology Grants and grants to establish Health Information Technology Regional Extension Centers, as authorized under the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act of 2009 (the Recovery Act).

Today I want to discuss the important term "meaningful use" of electronic health records (EHRs) – both as a concept that underlies the movement toward an electronic health care environment and as a practical set of standards that will be issued as a proposed regulation by the end of 2009.

The HITECH Act provisions of the Recovery Act create a truly historic opportunity to transform our health system through unprecedented investments in the development of a nationwide electronic health information system. This system will ultimately help facilitate, inform, measure, and sustain improvements in the quality, efficiency, and safety of health care available to every American. Simply put, health professionals will be able to give better care, and their patients' experience of care will improve, leading to better health outcomes overall.

As many of you are aware, the HITECH Act provides incentive payments to doctors and hospitals that adopt and meaningfully use health information technology. Eligible physicians, including those in solo or small practices, can receive up to $44,000 over five years under Medicare or $63,750 over six years under Medicaid for being meaningful users of certified electronic health records. Hospitals that become meaningful EHR users could receive up to four years of financial incentive payments under Medicare beginning in 2011, and up to six years of incentive payments under Medicaid beginning in October 2010.

The HITECH Act's financial incentives demonstrate Congress' and the Administration's commitment to help those who want to improve their care delivery, and will serve as a catalyst to accelerate and smooth the path to HIT adoption by more individual providers and organizations. The dollars are tangible evidence of a national determination to bring health care into the 21st century.

The Office of the National Coordinator for Health Information Technology (ONC) is charged with coordinating nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. ONC is working with the Centers for Medicare & Medicaid Services (CMS), through an open and transparent process, on efforts to officially designate what constitutes "meaningful use."

ONC has already engaged in a broad range of efforts to support the development of a formal definition of meaningful use. The HITECH Act designated a federal advisory committee, the HIT Policy Committee, with broad representation from major health care constituencies, to provide recommendations to ONC on meaningful use. The HIT Policy Committee has provided two sets of recommendations, informed by input from a variety of stakeholders. ONC and CMS have also conducted a series of listening sessions to solicit feedback from more than 200 representatives of various constituent groups and an open comment period where over 800 public comments were submitted and reviewed. The second set of recommendations on meaningful use was issued at a July 16 HIT Policy Committee meeting and details can be found at *healthit.hhs.gov/policycommittee*.

CMS is expected to publish a formal definition of meaningful use, for the purposes of receiving the Medicare and Medicaid incentive payments, by December 31, 2009. At that time, the public will be able to comment on the definition, and such comments will be considered in reaching any final definition of the term.

By focusing on "meaningful use," we recognize that better health care does not come solely from the adoption of technology itself, but through the exchange and use of health information to best inform clinical decisions at the point of care. Meaningful use of EHRs, we anticipate, will also enable providers to reduce the amount of time spent on duplicative paperwork and gain more time to spend with their patients throughout the day. It will lead us toward improvements and sustainability of our health care system that can only be attained with the help of a reliable and secure nationwide electronic health information system.

The concept of meaningful use is simple and inspiring, but we recognize that it becomes significantly more complex at a policy and regulatory level. As a result, we expect that any formal definition of "meaningful use" must include specific activities health care providers need to undertake to qualify for incentives from the federal government.

Ultimately, we believe "meaningful use" should embody the goals of a transformed health system. Meaningful use, in the long-term, is when EHRs are used by health care providers to improve patient care, safety, and quality.

Health information technology news – a message from Dr. Blumenthal (continued)

What's next?

As stated above, the next step in our process is a notice of proposed rulemaking in late 2009 with a public comment period in early 2010. As this process unfolds, we will continue to talk and share experiences about transitioning to EHRs, and to help deepen understanding among physicians and hospitals about the use of EHRs. We will also present programs designed to help smooth the transition process, and identify activities physicians and hospitals can engage in now to promote adoption of EHRs. As efforts advance, we will turn our attention to other necessary supporting programs, some of which you will hear more about in the coming weeks, including defining what constitutes a "certified" EHR, which is one of the requirements to qualify for Medicare and Medicaid incentives.

In the meantime, what can providers do to move toward becoming "meaningful users" – even in the absence of a formal definition? Naturally, while understanding that the final definition will be adopted through a formal rulemaking process, it will be helpful to be as familiar as possible with the discussion of meaningful use criteria to date. (You will find that information posted at *healthit.hhs.gov/meaningfuluse*.)

Armed with an understanding of the discussion of meaningful use as it unfolds, providers can begin to consider how their own practices or organizations might be reshaped to enhance the efficiency and quality of care through the use of an electronic health record system. Be assured you will not be alone as you seek to adopt an EHR system. Through our recently announced collaborative HITECH grants programs and others to be initiated later this year, we will continue to support providers in moving forward. Additional details about the grants are also available in my previous update and at *healthit.hhs.gov/HITECHgrants*.

To some providers, particularly small or already stretched physician practices or small, rural hospitals, the path toward meaningful use may still seem arduous. To others, who would just prefer to stick with the "status quo," it may seem like an unwanted intrusion. We believe that the time has come for coordinated action. The price of inaction – in adverse events, lost patient lives, delayed or improper treatments, unnecessary procedures, excessive costs, and so on – is just too high, and will only get worse.

There is much at stake and much to do. We must relieve the crushing burden of health care costs in this country by improving efficiency, and assuring the highest level of patient care and safety regardless of geography or demographics. By using current technologies in a meaningful way, as well as technology to be developed in the future, we will take great strides toward solving some of the most vexing problems facing our health care system and creating a new platform for innovative solutions to health care.

I look forward to providing periodic updates, and to continued interactions with all the communities that have so much to gain from this profound transformation.

Sincerely,

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

This letter is part of a series of ongoing updates from the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology. For more information and to receive regular updates from the Office of the National Coordinator for Health Information Technology, please subscribe to our Health IT News list at https://service.govdelivery.com/service/subscribe.html?code=USHHS_188.

If you have difficulty viewing this message, please view it online. To ensure that you receive future correspondence, please add this e-mail address to your list of secure addresses.

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

Source: CMS PERL 200910-26

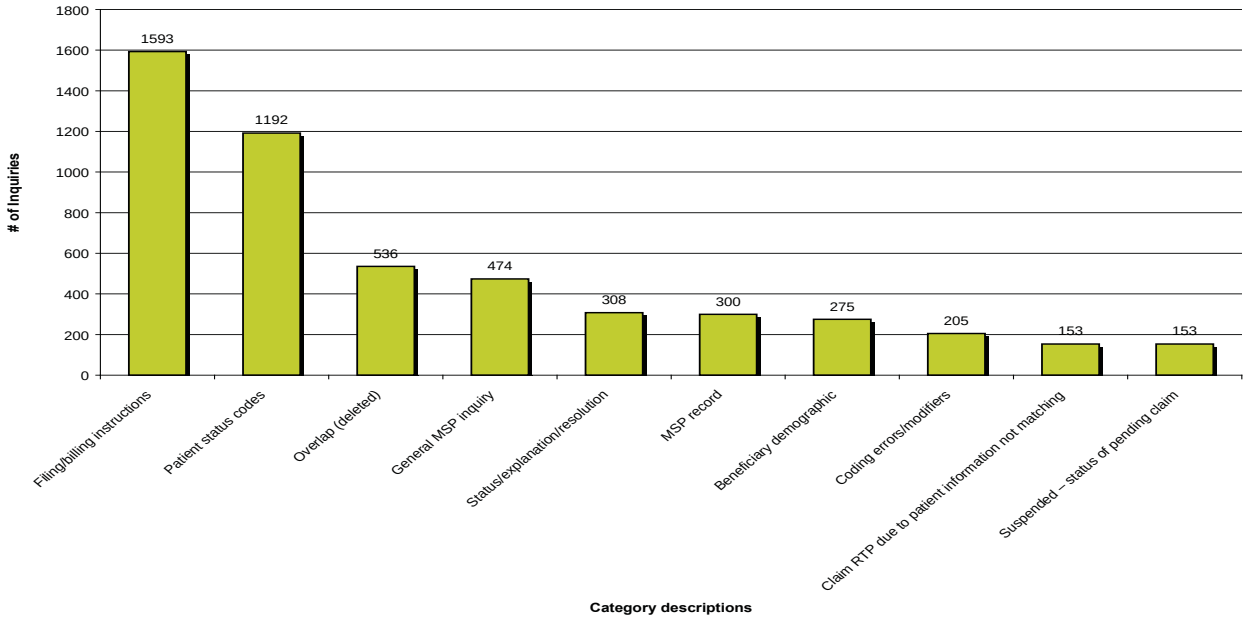
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for September 2009

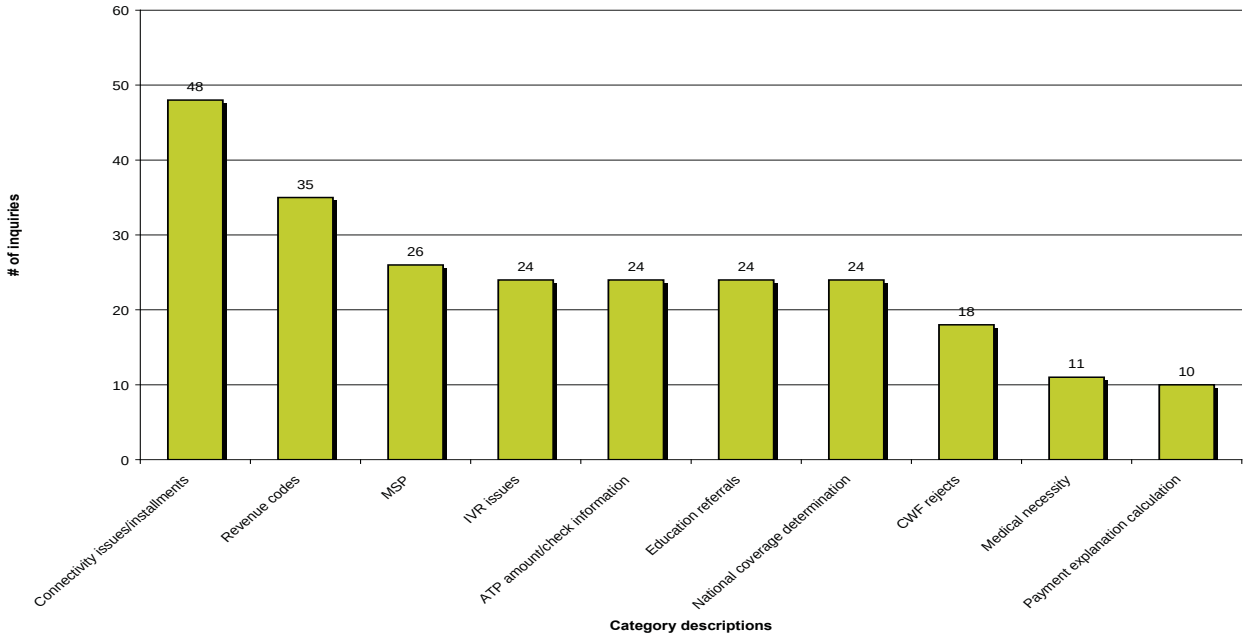
The following charts demonstrate the available top number of inquiries, the top reason codes for return to providers (RTPs), and reject claims submitted to First Coast Service Options Inc. (FCSO), by Florida, and U.S. Virgin Islands providers during September 2009.

For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for September 2009

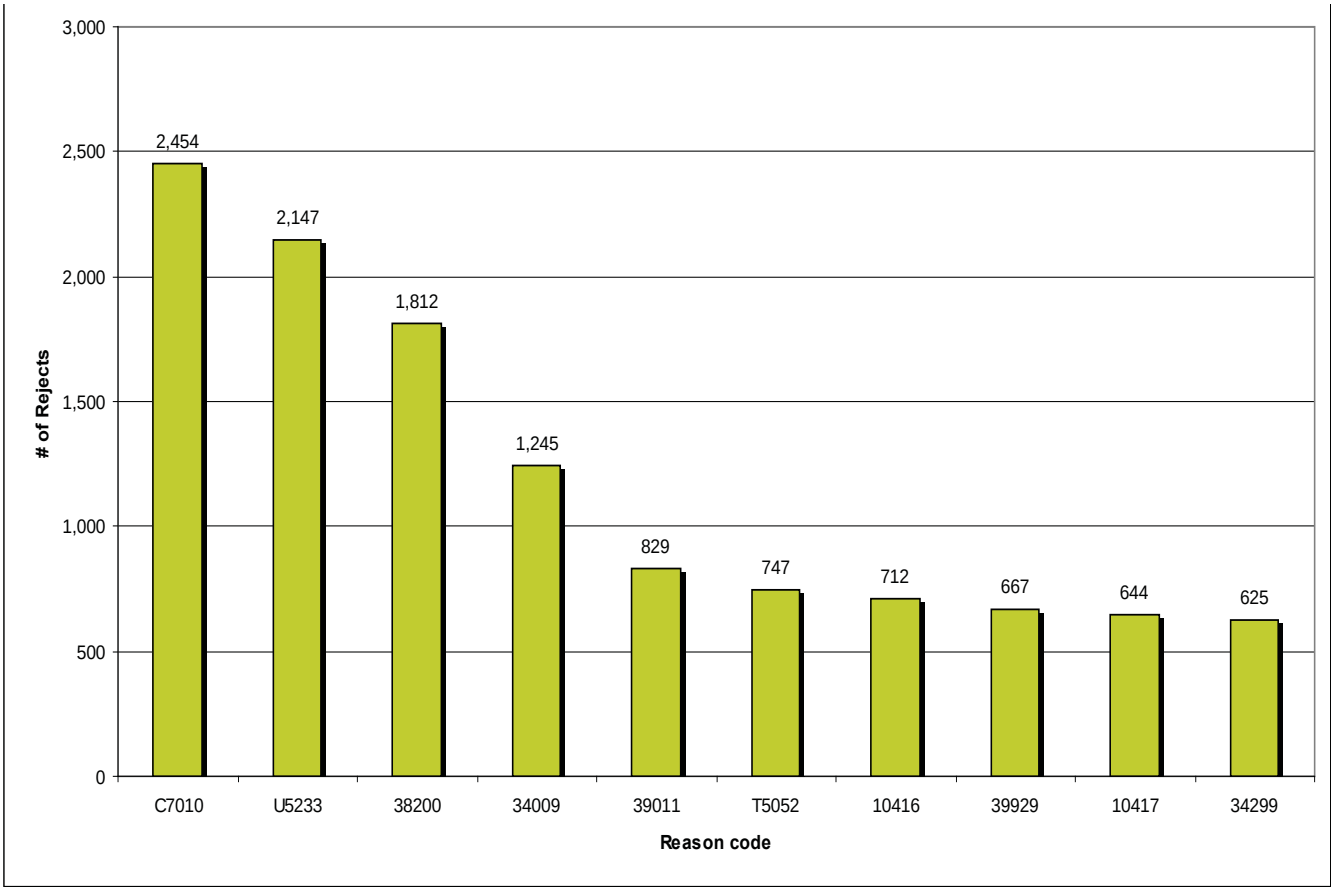


Puerto Rico and U.S. Virgin Islands Part A top inquiries for September 2009

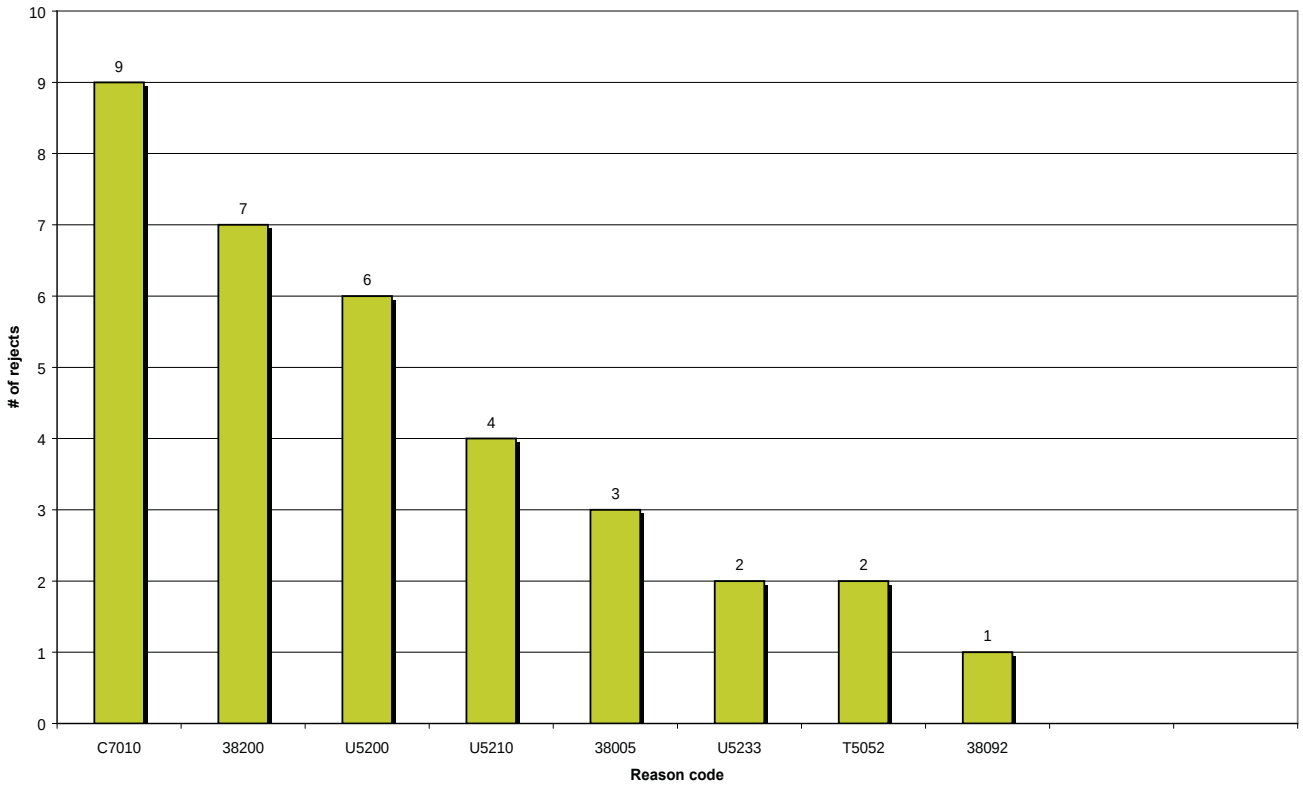


Top inquiries, return to provider, and reject claims for September 2009 (continued)

Florida Part A top rejects for September 2009

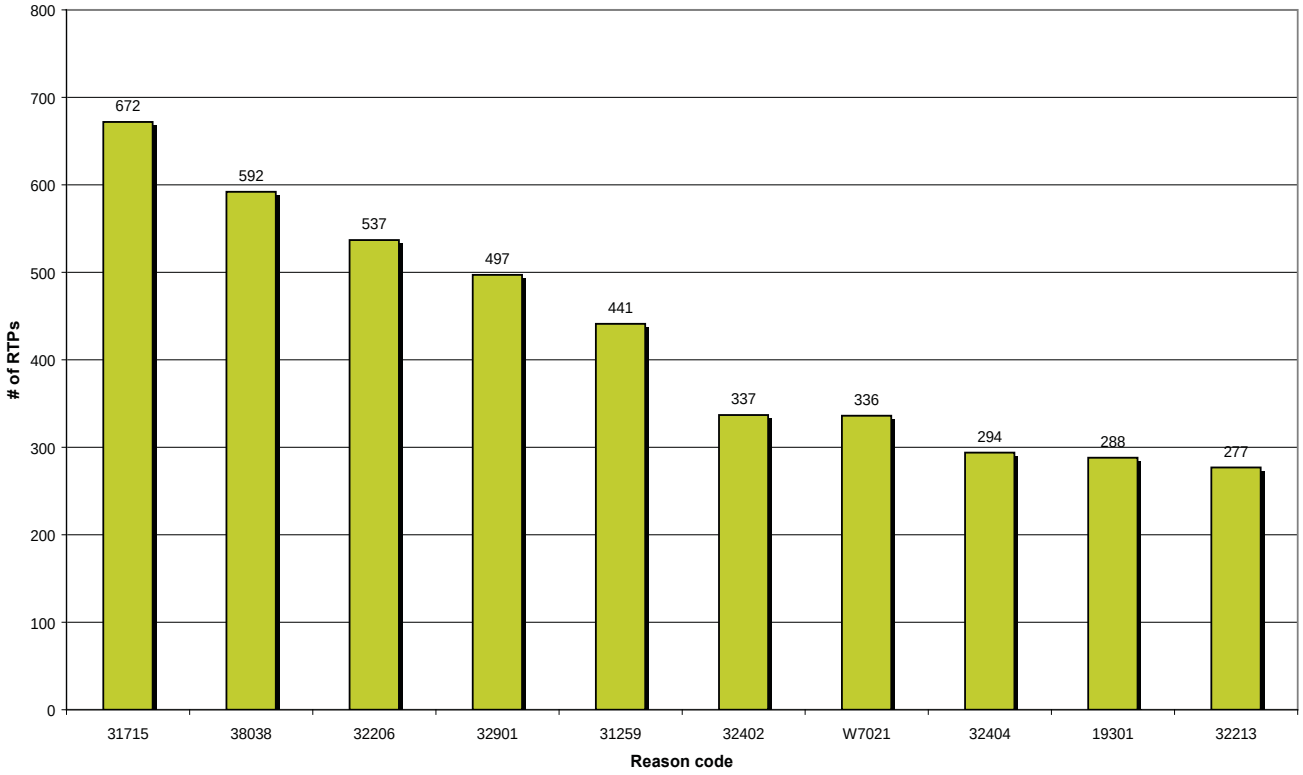


U.S. Virgin Islands Part A top rejects for September 2009



Top inquiries, return to provider, and reject claims for September 2009 (continued)

Florida Part A top RTPs for September 2009



Tips and steps to avoid reason code 32402

Q: What steps can we take to validate a healthcare common procedure coding system (HCPCS) code and avoid RTP reason code 32402 on our claims?

A: There are two options you can use to determine if a HCPCS code is valid:

- Through the claims inquiry menu in the direct data entry (DDE) system, you can choose option 14 and key in the HCPCS code. This will give you the list of revenue codes that may be billed with this HCPCS code. If there is no list of revenue codes, the HCPCS code can be used for all revenue codes.
- You can review the current HCPCS Level II coding manual (e.g., Ingenix) and follow the applicable guidelines. ❖

Find your favorites fast – use Quick Find

Looking for the fastest way to find your favorite sections of our Web site? It's easy – just use the Quick Find navigational tool. Located on the left-hand side of every page, this convenient drop-down menu allows you to jump to the most popular pages on the site – with just one click. You'll find links to the Part A and Part B homepages as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to find what you need fast – use Quick Find.

GENERAL COVERAGE

Annual clotting factor furnishing fee update

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

Provider types affected

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

What you need to know

Change request (CR) 6673, from which this article is taken, announces that for calendar year (CY) 2010, the blood clotting factor furnishing fee of $0.170 per international unit (I.U.) is added to the payment limit for a blood clotting factor that is not included on the average sale price (ASP) or not otherwise classified (NOC) files.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Section 303(e)(1) added section 1842(o)(5)(C) to the Social Security Act (the Act) which requires that, beginning January 1, 2005, a furnishing fee be paid for items and services associated with the administration of blood clotting factors.

It further specifies that for CY 2006 (and subsequent years) this furnishing fee will be equal to the fee for the previous year, increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The blood clotting furnishing factors for years 2005-2010 are displayed in the following table:

Blood Clotting Factor Furnishing Fee	
Furnishing fee	**Calendar year**
$0.170 per I.U.	2010
$0.164 per I.U	2009
$0.158 per I.U	2008
$0.152 per I.U	2007
$0.146 per I.U	2006
$0.140 per I.U	2005

Previously, the Centers for Medicare & Medicaid Services (CMS) included the clotting factor furnishing fee in the payment limit for Healthcare Common Procedure Coding System (HCPCS) code J7197 "Antithrombin III (human), per I.U.". This code does not describe a hemophilia clotting factor, and therefore the payment limit for it should not include the clotting factor furnishing fee. Thus, CR 6673 provides further clarification that the payment limit for J7197 does not include the clotting factor furnishing fee and Medicare will not make separate payment for the clotting factor furnishing fee for J7197.

Additional information

You may find more information about the blood clotting furnishing factor by going to CR 6673 located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1829CP.pdf*.

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

MLN Matters® Number: MM6673
Related Change Request (CR) Number: 6673
Related CR Release Date: October 16, 2009
Related CR Transmittal Number: R1829
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1829, CR 6673

Did you know?

If you are enrolled in Medicare but have not submitted a CMS-855 since 2003, you are required to submit a complete application. Providers and suppliers should follow the instructions for completing an initial enrollment application.

Magnetic resonance imaging

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [MAC]) should be aware of this issue if they provide magnetic resonance imaging (MRI) services to Medicare beneficiaries.

What you need to know

Historically, the use of MRI for blood flow determination has been a Medicare "noncovered" procedure. CR 6672, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) found that the noncoverage of MRI for blood flow determination is no longer supported by the available evidence. Therefore, effective September 28, 2009, CMS is removing blood flow measurement as a nationally noncovered indication for MRI, and is giving local Medicare contractors the discretion to cover (or not to cover) this use of MRI in blood flow measurement. You should ensure that your billing staffs are aware of this change.

Background

CMS received a request to delete the national noncoverage of blood flow measurement from the MRI national coverage determination (NCD) in section 220.2 (Magnetic Resonance Imaging), Subsection C.2 (National Noncovered Indications) of the *Medicare National Coverage Determinations Manual* because of an apparent contradiction between this noncoverage provision and the national coverage of MRI under the magnetic resonance angiography NCD in Section 220.3 (Magnetic Resonance Angiography).

In concert with this change, the following four *Current Procedural Terminology* (*CPT*) codes will be changed from "noncovered" to "covered" and will appear in the January 2010 integrated outpatient code editor (IOCE) quarterly updates:

75558 *Cardiac magnetic resonance imaging for morphology and function without contrast materials; with flow/velocity quantification*

75560 *Cardiac magnetic resonance imaging for morphology and function without contrast materials; with flow/velocity quantification and stress*

75562 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification*

75564 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress*

Please note that all other MRI uses noted in the *NCD Manual*, Section 220.2 remain unchanged, including noncoverage of imaging of cortical bone and calcifications, procedures involving spatial resolution of bone and calcifications, for patients with FDA-approved (for an MRI environment) implanted cardioverter-defibrillators or cardiac pacemakers, or for patients with metallic clips on vascular aneurysms.

CMS also received a separate request to revise the reference to cardiac pacemakers to permit coverage for MRI when a beneficiary has an implanted device that has been designed, tested and Food and Drug Administration (FDA)-labeled for use in the MRI environment. In response to this request, CMS has not found evidence that MRI improves health outcomes in beneficiaries who have an implanted cardioverter-defibrillator or cardiac pacemaker approved by FDA for use in an MRI environment; in fact, CMS notes that there are currently no such devices. Therefore, no changes are proposed as a result of this request and the current policy remains in effect.

Note that your Medicare contractor will not search for previously-processed claims with dates of service of September 28, 2009, through December 31, 2009, but will adjust any claims that you bring to their attention.

Additional information

CR 6672 was issued in two transmittals. One transmittal updated the *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determination, Section 220.2 (Magnetic Resonance Imaging) and that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R107NCD.pdf*.

The other transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R1831CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 40 (Magnetic Resonance Imaging (MRI) Procedures).

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

MLN Matters® Number: MM6672
Related Change Request (CR) Number: 6672
Related CR Release Date: October 16, 2009
Related CR Transmittal Number: R1831CP and R107NCD
Effective Date: September 28, 2009
Implementation Date: January 4, 2010

Source: CMS Pub. 100-03, Transmittal 107, CR 6672

FDG positron emission tomography for solid tumors and myeloma

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

Provider types affected

This article is for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) when providing F-18 flouro-D-glucose (FDG) positron emission tomography (PET) scans to Medicare beneficiaries. Note that the term FDG PET includes FDG PET/CT (computed tomography).

What you need to know

Change request (CR) 6632, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare National Coverage Determinations Manual*, Section 220.6: Positron Emission Tomography (PET) Scans. Specifically, in CR 6632, CMS announces (effective April 3, 2009) a national coverage determination (NCD) that adopts a two-part framework which differentiates the use of F-18 flouro-D-glucose (FDG) PET imaging in the initial antitumor treatment strategy, from its other uses related to guiding subsequent antitumor treatment strategies after the completion of initial treatment. This framework replaces the previous, four-part framework that contained the diagnosis, staging, restaging, and monitoring response to treatment.

Background

The NCD that CR 6632 announces requires the replacement of the four-part framework (mentioned in the previous paragraph) with a two-part one that differentiates FDG PET imaging used for initial antitumor treatment strategy from subsequent antitumor treatment strategies after the completion of initial treatment. In so doing, it provides that (effective for services provided on or after April 3, 2009) the terms "diagnosis" and "staging" are to be replaced with "Initial Treatment Strategy," and the terms "restaging" and "monitoring" are to be replaced with "Subsequent Treatment Strategy."

National coverage determination requirements

Initial antitumor treatment strategy

CMS will cover one FDG PET study for beneficiaries who have solid tumors that are biopsy proven or strongly suspected based on other diagnostic testing when the beneficiary's treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to the initial treatment strategy:

- Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; or
- The optimal anatomic location for an invasive procedure; or
- The anatomic extent of tumor when the recommended antitumor treatment reasonably depends on the extent of the tumor.

There are some exceptions to this initial treatment strategy:

- CMS will nationally non-cover the use of FDG PET imaging to determine initial treatment strategy in patients with adenocarcinoma of the prostate.
- CMS will continue to cover FDG PET imaging for the initial treatment strategy for male and female breast cancer when used in staging distant metastasis. FDG PET imaging for diagnosis and initial staging of axillary nodes will remain noncovered.
- CMS will continue non-coverage of FDG PET for the evaluation of regional lymph nodes in melanoma. Other uses to determine initial treatment strategy remain covered.
- CMS will continue to cover FDG PET imaging as an adjunct test for the detection of pre-treatment metastasis (i.e., staging) in newly diagnosed cervical cancers following conventional imaging that is negative for extra-pelvic metastasis. All other uses of FDG PET for the initial treatment strategy for beneficiaries diagnosed with cervical cancer will only continue to be covered through coverage with evidence development (CED).

Specifically, CMS will cover one initial FDG PET study for patients with newly diagnosed cervical cancer (when not used as an adjunct test to detect pre-treatment metastases following conventional imaging that is negative for extra-pelvic metastasis) only when the beneficiary's treating physician determines that the FDG PET study is needed to inform the initial antitumor treatment strategy, and the beneficiary is enrolled in, and the FDG PET provider is participating in, an FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Clinical studies for which CMS will provide coverage must answer one or more of the following three questions:

Prospectively, in Medicare beneficiaries with newly diagnosed cervical cancer who have not been found following conventional imaging to be negative for extra-pelvic metastases and whose treating physician determines that the FDG PET study is needed to inform the initial antitumor treatment strategy, does the addition of FDG PET imaging lead to:

- A change in the likelihood of appropriate referrals for palliative care,
- Improved quality of life, or
- Improved survival?

The study must adhere to the standards of scientific integrity and relevance to the Medicare population as described in the following section on subsequent antitumor strategy (items a through m, below).

Subsequent antitumor treatment strategy

For tumor types other than breast, colorectal, esophagus, head and neck (non-CNS/thyroid), non-small cell lung, and thyroid cancers, lymphoma, and melanoma, CMS has determined that FDG PET imaging for subsequent antitumor treatment strategy may be covered as research through CED.

FDG positron emission tomography for solid tumors and myeloma (continued)

However, CMS will cover a subsequent FDG PET study for tumor types other than breast, colorectal, esophagus, head and neck (non-CNS/thyroid), non-small cell lung, and thyroid cancers, lymphoma, and melanoma, when the beneficiary's treating physician determines that the FDG PET study is needed to inform the subsequent antitumor treatment strategy and the beneficiary is enrolled in, and the FDG PET provider is participating in, the following types of prospective clinical study:

- A FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Qualifying clinical studies must ensure that specific hypotheses are addressed; appropriate data elements are collected; hospitals and providers are qualified to provide the PET scan and interpret the results; participating hospitals and providers accurately report data on all enrolled patients not included in other qualifying trials through adequate auditing mechanisms; and all patient confidentiality, privacy, and other federal laws must be followed.

The clinical studies for which CMS will provide coverage must answer one or more of the following three questions:

Prospectively, in Medicare beneficiaries whose treating physician determines that the FDG PET study is needed to inform the subsequent antitumor treatment strategy, does the addition of FDG PET imaging lead to:

- A change in the likelihood of appropriate referrals for palliative care,
- Improved quality of life, or
- Improved survival?

The study must adhere to the following standards of scientific integrity and relevance to the Medicare population:

a. The principal purpose of the research study is to test whether a particular intervention improves the participant's health outcomes.

b. The research study is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

c. The research study does not unjustifiably duplicate existing studies.

d. The research study design is appropriate to answer the research question being asked in the study.

e. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.

f. The research study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in the *Code of Federal Regulations* (CFR) at 45 CFR 46. If a study is regulated by the Food and Drug Administration (FDA), it also must be in compliance with 21 CFR Parts 50 and 56.

g. All aspects of the research study are conducted according to the appropriate standards of scientific integrity.

h. The research study has a written protocol that clearly addresses, or incorporates by reference, the Medicare standards.

i. The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in health individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life-threatening as defined in 21 CFR 312.81(a) and the patient has no other viable treatment options.

j. The clinical research study is registered on the *http://www.clinicaltrials.gov* Web site by the principal sponsor/investigator prior to the enrollment of the first study subject.

k. The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if such are negative or the study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors. However, a full report of the outcomes must be made no later than three years after the end of data collection.

l. The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

m. The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Consistent with Section 1142 of the Social Security Act, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

As exceptions to the subsequent treatment strategy section above:

- CMS has determined that FDG PET for subsequent treatment strategy in Medicare beneficiaries with ovarian cancer is nationally covered.

FDG positron emission tomography for solid tumors and myeloma (continued)

- CMS has determined that FDG PET for subsequent treatment strategy in Medicare beneficiaries with cervical cancer is nationally covered.

Myeloma

CMS has determined that FDG PET for initial treatment strategy and subsequent treatment strategy in Medicare beneficiaries with myeloma is nationally covered.

Further exceptions

CMS will continue to cover FDG PET for subsequent treatment strategy for specific indications in the following nine tumor types:

- Breast
- Cervix
- Colorectal
- Esophagus
- Head and neck (non-CNS/thyroid)
- Lymphoma
- Melanoma
- Non-small cell lung
- Thyroid

The CMS has transitioned the prior framework—diagnosis, staging, restaging, and monitoring response to treatment—into the initial treatment strategy and subsequent treatment strategy framework while maintaining current coverage.

The chart below summarizes Section 220.6.1:

FDG PET coverage for solid tumors and myeloma

Tumor type	Initial treatment strategy (formerly "diagnosis" & "staging")	Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment")
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	CED
Cervix	See note (1) below or CED	Cover
Small cell lung	Cover	CED
Soft tissue sarcoma	Cover	CED
Pancreas	Cover	CED
Testes	Cover	CED
Breast (female and male)	See note (2)	Cover
Melanoma	See note (3)	Cover
Prostate	Noncover	CED
Thyroid	Cover	See note (4) or CED
All other solid tumor	Cover	CED
Myeloma	Cover	Cover
All other cancers not listed herein	CED	CED

FDG positron emission tomography for solid tumors and myeloma (continued)

Notes:
(1) Cervix: Covered for the detection of pre-treatment metastases (i.e., staging) in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis. All other uses are CED.

(2) Breast: Noncovered for initial diagnosis and/or staging of axillary lymph nodes. Covered for initial staging of metastatic disease.

(3) Melanoma: Non-covered for initial staging of regional lymph nodes. All other uses for initial staging are covered.

(4) Thyroid: Covered for subsequent treatment strategy of recurrent or residual thyroid cancer of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and have a negative I-131 whole body scan. All other uses for subsequent treatment strategy are CED.

Coding and billing requirements

CR 6632 also announces new modifiers for PET imaging, effective for services provided on or after April 3, 2009.

PI – Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.
Short descriptor: PET tumor init tx strat

PS – Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent antitumor strategy.
Short descriptor: PET tumor subsq tx strategy

Note: The two new FDG PET oncologic modifiers are included in the July quarterly update of the integrated outpatient code editor (IOCE) with an effective date of April 1, 2009. As of October 30, 2009, all FDG PET oncologic-related claims for dates of service on or after April 3, 2009, must include one of these two new modifiers in order for the claim to be processed correctly.

Medicare claims processing requirements in CR 6632 are as follows:

- For claims with dates of service on or after April 3, 2009, Medicare will accept and pay for FDG PET claims as specified in the CR 6632 NCD to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors.

Claims that your carrier, FI, or A/B MAC receive after October 30, 2009 (for dates of service on or after April 3, 2009), will return as unprocessable (professional claims) or as return to provider (institutional claims) if they do not include **modifier PI** with one of the following PET or PET/CT *CPT* codes when billing to inform the initial treatment strategy for solid tumors:

78608	*78811*	*78812*	*78813*
78814	*78815*	or *78816*	

- Your carrier or A/B MAC will return as unprocessable those professional claims for the subsequent treatment strategy without **modifier PS and** a *CPT* code of *78608*, *78811*, *78812*, *78813*, *78814*, *78815*, or *78816*, **and** an ICD-9-CM cancer diagnosis code.

Should your carrier, FI, or A/B MAC return your claim that does not contain **modifier PI or PS**, they will use the following messages:

Claim adjustment reason code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

Remittance advice remark code MA-130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remittance advice remark code M16 – Alert: Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

For claims with dates of service on or after April 3, 2009, Medicare will accept and pay for FDG PET oncologic claims billed for initial or subsequent treatment strategy when performed under CED only when billed with the following:

- PET/PET/CT *CPT* code *78608*, *78811*, *78812*, *78813*, *78814*, *78815*, *or 78816* **and**
- Modifier PI, **or**
- Modifier PS, **and** an ICD-9-CM cancer code diagnosis code, **and**
- Modifier Q0.

For claims with dates of service on or after April 3, 2009, Medicare will return as unprocessable, return to provider, FDG PET oncologic claims for initial or subsequent treatment strategy when performed under CED billed without:

- PET/PET/CT *CPT* code *78608*, *78811*, *78812*, *78813*, *78814*, *78815*, or *78816*, **and**
- Modifier PI, **or**
- Modifier PS, **and** an ICD-9-CM cancer code diagnosis code, **and**
- Modifier Q0.

You should also be aware that your carrier, FI, or A/B MAC will not search their files for FDG PET oncologic-related claims with dates of service April 3, 2009, through October 29, 2009, processed prior to October 30, 2009. However, they may adjust claims that you bring to their attention.

Additional information

CR 6632 was issued in two transmittals. One transmittal conveys the revisions to the *Medicare National Coverage Determinations Manual*, and the other conveys the changes to the *Medicare Claims Processing Manual*.

FDG positron emission tomography for solid tumors and myeloma (continued)

These transmittals are on the CMS Web site respectively at *http://www.cms.hhs.gov/Transmittals/downloads/R108NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1833CP.pdf*.

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

MLN Matters® Number: MM6632
Related Change Request (CR) Number: 6632
Related CR Release Date: October 16, 2009
Related CR Transmittal Number: R1833CP and R108NCD
Effective Date: April 3, 2009
Implementation Date: October 30, 2009

Source: CMS Pub. 100-04, Transmittal 1817, CR 6632

Clari cation of the use of modi ers when billing wrong surgery on a patient

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

Provider types affected

This article is for physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Healthcare Common Procedure Coding System (HCPCS) **modifier PC** (wrong surgery on patient) was recently established in change request (CR) 6405, along with two other modifiers, for use in Medicare billing, to be appended, where appropriate, to all claim lines related to a surgical error.

Caution – what you need to know

Some providers or their billing services may be incorrectly using the HCPCS **modifier PC** to indicate the professional component for certain services not related to surgical error when the **modifier 26** should have been used. **You need to be aware that the use of the modifier PC on Medicare claims will result in the claim being denied.**

Go – what you need to do

Please be sure that you and your billing personnel/ services prepare claims submitted to Medicare with the correct codes in order for the claims to process correctly.

Background

This special edition article clarifies the correct use of certain HCPCS modifiers. To briefly clarify, please note that:

- **Modifier PC** is used to identify wrong surgery on patient. The modifier PC is to be appended, where appropriate, to all claim lines related to a surgical error.
- **Modifier 26** is used to identify the professional component of a service or a procedure.

As appropriate, please review "MM6405: Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient," which explains the wrong surgery HCPCS modifiers. This article is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf*.

Additional information

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

MLN Matters® Number: SE0927
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 SE0927

In uenza vaccine payment allowances – annual update for 2009-2010 season

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

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6608 to update payment allowances, effective September 1, 2009, for influenza vaccines when payment is based on 95 percent of the average wholesale price (AWP).

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC), in which cases, payments for the vaccines are based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Key points

The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year. CR 6608 provides the payment allowances for the following influenza virus vaccines: *Current Procedural Terminology* (*CPT*) codes *90655*, *90656*, *90657*, *90658*, and *90660* when payment is based on 95 percent of the AWP.

Note: For information about billing the H1N1 influenza vaccine, please see the *MLN Matters*® article on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6617.pdf*.

Effective September 1, 2009, these Medicare Part B payment allowances for influenza vaccines are as follows:

CPT code	Allowance
90655	$15.447
90656	$12.541
90657	$5.684
90658	$11.368

CPT 90660 (influenza virus vaccine, live, for intranasal use [FluMist®]) may be covered if the local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for *CPT 90660* is $22.316 (effective September 1, 2009).

These payment allowances were published as a part of the July 2009 quarterly ASP drug pricing files, as specified in CR 6471. See *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6471.pdf* on the CMS Web site to view the article related to CR 6471.

Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 6608. However, they will adjust such claims that you bring to their attention.

Additional information

You may find the official instruction, CR 6608, issued to your Medicare carrier, FI or A/B MAC by visiting the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1824CP.pdf*.

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

Educational products are available through the MLN catalogue free of charge. The MLN catalogue is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf*.

The specific products that may be of interest to providers who use the information in MM6608 are as follows:

- The *Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B)* is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.
- The *Adult Immunizations* brochure provides a basic overview of Medicare influenza, pneumococcal and hepatitis B vaccine benefits and is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.

MLN Matters® Number: MM6608
Related Change Request (CR) Number: 6608
Related CR Release Date: October 2, 2009
Related CR Transmittal Number: R1824CP
Effective Date: September 1, 2009
Implementation Date: November 2, 2009

Source: CMS Pub. 100-04, Transmittal 1824, CR 6608

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 noti cation

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

Table of contents

Additions/revisions to existing LCDs

A70544: Magnetic resonance angiography (MRA) 28
Intravitreal bevacizumab (Avastin®) 28
AJ3487: Zoledronic acid 28
ASKINSUB: Skin substitutes 29
ATHERSVCS: Therapy and rehabilitation services 29

Additional Medical Information

A77371: Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – coding guidelines 29
AJ0881: Erythropoiesis stimulating agents – clarification on coding . 31
Signature requirement clarification 33

Advance bene ciary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our provider education Web site at *http://medicare.fcso.com*.

ADDITIONS/REVISIONS TO EXISTING LCDS

A70544: Magnetic resonance angiography (MRA) – revision to the LCD

LCD ID Number: L28903 (Florida)
LCD ID Number: L28925 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for magnetic resonance angiography (MRA) was last revised on October 1, 2009. Since that time, the LCD has been revised based on Change Request 6338, Transmittal 477, dated April 24, 2009. The type of bill code used to identify federally qualified health centers (FQHCs) was changed from 73x to 77x.

Effective date

This LCD revision is effective **October 5, 2009** for services provided **on or after April 1, 2010**. 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. ❖

Intravitreal bevacizumab (Avastin®) – revision to the LCD

LCD ID Number: L29933 (Florida)
LCD ID Number: L29935 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) was effective for services provided on or after June 30, 2009. Since that time, the LCD has been revised in accordance with CMS Transmittal 1810, Change Request 6617, dated September 1, 2009, the "*CPT*/HCPCS Codes"' section of the LCD has been revised to delete HCPCS code J3490 (unclassified drugs) and replace it with HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg).

The LCD "Coding Guidelines" attachment has been revised to indicate HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg) is used to appropriately describe smaller doses that total less than 10 mg of bevacizumab (Avastin®). This smaller dose should be billed for the Food and Drug Administration (FDA)-approved treatment of metastatic colorectal cancer (i.e., ICD-9-CM codes 153.0-153.9, 154.0-154.3, 154.8, 197.5). HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg) should also be billed for intravitreal bevacizumab, along with *CPT* code *67028* (Intravitreal injection of a pharmacologic agent).

Effective date

This LCD revision is effective for services provided **on or after October 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. ❖

AJ3487: Zoledronic acid – revision to the LCD

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

The local coverage determination (LCD) for zoledronic acid was last revised on June 30, 2009. Since that time, the Food and Drug Administration (FDA) approved a new indication for zoledronic acid (Reclast ®), HCPCS code J3488, effective May 29, 2009. This new indication is for the prevention of osteoporosis in postmenopausal women.

The "Indications and Limitations of Coverage and/or Medical Necessity," "ICD-9 Codes that Support Medical Necessity," "Utilization Guidelines," and the "Coding Guidelines" attachment have all been revised to allow for coverage of this new indication. When billing for this new indication, providers will be required to bill ICD-9-CM code V49.81 (Asymptomatic postmenopausal status [age-related] [natural]).

Effective date

This LCD revision is effective for services provided **on or after May 29, 2009,** for claims processed **on or after November 5, 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. ❖

ASKINSUB: Skin substitutes – revision to the LCD

LCD ID Number: L28985 (Florida)
LCD ID Number: L29327 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was last revised on July 1, 2009. Since that time, a revision was made to the LCD based on Change Request 6626 (October 2009 Update of the Hospital Outpatient Prospective Payment System [OPPS]) issued by the Centers for Medicare & Medicaid Services (CMS). CMS changed the status indicator for HCPCS code Q4115 to "K" to indicate that separate payment may be made for this product. However, a review of HCPCS code Q4115 determined that this skin substitute code should be added to the Non-Covered Products section of the "CPT/HCPCS Codes" section of the LCD.

Q4115 Skin substitute, Alloskin, per square centimeter

Effective date

This revision to the LCD is effective for claims processed **on or after October 5, 2009**, for services provided **on or after October 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. ❖

ATHERSVCS: Therapy and rehabilitation services – revision to the LCD

LCD ID Number: L28992 (Florida)
LCD ID Number: L29024 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on August 11, 2009. Since that time, the LCD has been revised based on Change Request 6338, Transmittal 477, dated April 24, 2009. The type of bill code used to identify federally qualified health centers (FQHCs) was changed from 73x to 77x."

Effective date

This LCD revision is effective **October 5, 2009,** for services provided **on or after April 1, 2010.**
First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

ADDITIONAL MEDICAL INFORMATION

A77371: Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – coding guidelines

LCD ID Number: L30364 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) is effective for services provided on or after October 5, 2009. First Coast Service Options Inc. (FCSO) has developed an LCD coding guideline attachment for these services that reads as follows:

Coding and pricing – MCS vs. FISS

SRS/SBRT treatment delivery is a technical service that results in claims for a facility. Hospital based facilities send claims to the fiscal intermediary shared system (FISS) for administration and payment usually via OPPS (outpatient prospective payment system). Free standing facilities send claims to the Medicare carrier system (MCS) for administration and payment via the Medicare physician fee schedule database (MPFSDB). The active codes for the two systems are not a complete cross walk and the payment is different given the different payment methodologies.

There are two LCDs for SRS/SBRT treatment delivery – one addressing the Part A system (FISS – outpatient hospital facility claims) and one addressing Part B system (MCS – for free standing facility claims). Physician management services are not directly addressed though the applicable coding guidance in *CPT* and other applicable LCD(s) may apply. Physician services are all Part B system (MCS) claims.

The current active Part A (FISS system) codes for SRS/SBRT treatment delivery are *CPT*/HCPCS codes *77371*, G0173, G0251, G0339 and G0340.

A77371: Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – coding guidelines (continued)

The current active Part B (MCS system) codes for SRS/SBRT treatment delivery are *CPT* codes *77371, 77372* and *77373*, which are priced in the MPFSDB. HCPCS codes G0339 and G0340 are currently carrier priced codes and the contractor maps these codes to *CPT* code *77373* pricing, since the contractor has adopted the CPT guidance that is supported by the RUC for any brand of SBRT treatment delivery.

CPT code *77373*

Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

Free standing facilities billing Part B (MCS system) for SBRT treatment delivery are expected to submit one unit for *CPT* code *77373* per day up to five days (5 fractions) when reasonable and necessary. HCPCS codes G0339 and G0340 are administered as *CPT* code *77373*. Both the G code and *CPT* code *77373* code cannot be submitted on the same day and the Medicare beneficiary should not have liability beyond their applicable co-payment/deductible for *CPT* code *77373* no matter which code is used. In cases where coverage is in question, it is recommended that an advanced beneficiary notice (ABN) be used. Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Medicare fee-for-service (FFS). See the Centers for Medicare & Medicaid Services (CMS) Web site for specific information *http://www.cms.hhs.gov/bni/*.

Number of units of dosimetry (*CPT* code *77300*) submitted in an SRS/SBRT episode of care

CPT code *77300*

Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

The validated process of care for *CPT* code *77300* (*CPT* code and RUC) does not support the units of *CPT* code *77300* dosimetry that are billed for SRS/SBRT by certain centers in Florida. In the past the contractor would see single units billed (4-8) on a given day for the episode of care. However, some centers started billing 10-20 times (80 to 200, and more) the units for similar cases. The contractor clarified with experts in the field as well as reviewed input in the public domain from ASTRO. ASTRO does not recommend that all 100 – 200 beams be billed individually as a separate service (*CPT* code *77300*), and the contractor concurs, since the work done cannot be supported by billing that amount of total RVUs. While more may be medically indicated under certain circumstances, more than ten times per course for SBRT should be very rare, and the contractor would more typically see 4 to 8 units based on previous claims history.

Coding for SRS and SBRT surgical specialty vs. radiation oncologist physician services

As noted in the *American Medical Association (AMA) CPT Changes 2009: An Insider's View*, significant changes have been made to the *CPT* coding system for reporting stereotactic radiosurgery (SRS). When *CPT* code *61793* was added to the *CPT* codebook, the technology and technique of SRS was first emerging. Since that time, broader indications have been developed for SRS. Due to these changes in the technology, *CPT* code 61793 no longer adequately describes the physician work involved in the procedures. To accurately reflect the current practice of SRS, *CPT* code *61793* has been deleted and seven new codes have been established. These new codes are listed **under new subheadings** (Stereotactic Radiosurgery (Cranial) (*CPT* codes *61795-61800*) **and** Stereotactic Radiosurgery (Spinal) (*CPT* codes *63620-63621*) with guidelines to provide education for reporting these codes.

It is important to note that these new codes are not intended to report stereotactic body radiation therapy for lesions that are neither cranial nor spinal. It is also important to note that the primary codes in this series for *CPT* codes *61796, 61798* and *63620* are very heavily weighed and include significant work by the surgeon that must be documented.

The radiation oncologist reports the appropriate code(s) for clinical treatment planning, physics and dosimetry, treatment delivery and management from the **Radiation Oncology** section (*77xxx* series *CPT* codes). Any necessary planning, dosimetry, targeting, positioning, or blocking by the neurosurgeon or head and neck surgeon with SRS/SBRT training is included in the **stereotactic radiation surgery** services. The same physician should not report stereotactic radiosurgery services with radiation oncology services. If both a radiation oncologist and neurosurgeon/head and neck surgeon are performing work involving planning, dosimetry, targeting, positioning, or blocking, and management of treatment delivery, each physician should use the appropriate code(s) for the necessary work they performed (surgery section vs. radiation oncology).

To report stereotactic body radiation therapy for lesions that are neither cranial nor spinal, the radiation oncologist uses the appropriate *77xxx* series *CPT* codes. If a **surgeon** with appropriate training in SBRT is also contributing work to the episode of care, that service should be reported with the **unlisted** *CPT* code *77499 (Unlisted procedure, therapeutic radiology treatment management)* and the documentation must support the necessary work by the second physician

Claims for SBRT with diagnosis of prostate cancer

SBRT for the treatment of prostate cancer currently does not have a positive coverage statement in the Part A and Part B LCDs given the lack of data on long-term toxicities and outcomes. Such claims will be developed (request for documentation) and payment will be considered on a case by case basis with attention to the physician documentation for that patient. It is recommended that

A77371: Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – coding guidelines (continued)

facilities submit one claim for the treatment delivery code with the relevant treatment delivery dates so that only one letter is generated for the request for records.

In cases where coverage is in question, it is recommended that an ABN be used. Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Medicare FFS. See CMS Web site for specific information *http://www.cms.hhs.gov/bni/*.

Effective date

This new LCD coding guideline attachment is effective for services provided **on or after October 5, 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. ❖

AJ0881: Erythropoiesis stimulating agents – clari cation on coding

LCD ID Number: L28836 (Florida)
LCD ID number: L28869 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the erythropoiesis stimulating agents was last revised on October 1, 2009. First Coast Service Options Inc. (FCSO) recently implemented a revised LCD that streamlined the coding for all erythropoiesis stimulating agents (ESAs). FCSO published an article that summarized all coding rules for the LCD to make it easier for providers to code and bill their claims correctly. The LCD was recently revised based on the annual 2010 ICD-9-CM update. New ICD-9-CM codes were added for HCPCS codes J0881 and J0885. With the addition of these new codes, FCSO implemented a new dual diagnosis rule that previously was not required. FCSO is taking this opportunity to revise the previous article published which summarized ESA coding and is now outlining the new coding rules effective October 1, 2009. This article will also serve to summarize all the rules for billing non-ESRD ESAs (HCPCS codes J0881 and J0885) implemented since April 7, 2008, and how they apply to this LCD. Any questions on this LCD should be submitted to the medical policy department at medical.policy@fcso.com.

HCPCS codes J0881 and J0885 include two lists of ICD-9-CM codes each. The two lists for HCPCS codes J0881 and J0885 outline which ESA modifier (EA or EC) must be billed with the ICD-9-CM codes and also include the dual diagnosis requirements for the ICD-9-CM codes. These modifier designation and dual diagnosis rules are found at the beginning of each list for HCPCS codes J0881 and J0885. ICD-9-CM codes that require a dual diagnosis are designated with an asterisk (*). In addition, the "Coding Guidelines" attachment for the LCD continues to have instructions for providers on how to bill for certain noncovered indications outlined in the national coverage determination (NCD) 110.21.

Coding changes

J0881: This list **does** require a dual diagnosis.

The following ICD-9-CM codes require **modifier EA** and a dual diagnosis: 285.3 and one of the following must be billed together:

140.0-149.9	150.0-159.9	160.0-165.9
170.0-176.9	179-189.9	190.0-199.2
200.00-200.88	201.00-201.98	202.00-202.98
203.00-203.82	204.00-204.92	209.00-209.03
209.10-209.17	209.20-209.29	209.30-209.36
209.70-209.79	230.0-234.9	235.0-235.9
236.0-236.99	237.0-237.9	238.0
238.1	238.2	238.3
238.4	238.5	238.6
238.8	238.9	or 239.0-239.9

J0881: This list **does not** require a dual diagnosis

The following ICD-9-CM codes require **modifier EC**:

238.71	238.72	238.73
238.74	238.75	238.76
or 273.3.		

J0881: This list **does** require a dual diagnosis.

The following ICD-9-CM codes require **modifier EC** and a dual diagnosis (*): 285.21* **and** one of the following must be billed together:

403.01*	403.11*	403.91*
404.02*	404.03*	404.12*
404.13*	404.92*	404.93*
585.1*	585.2*	585.3*
585.4*	585.5*	or 585.9*.

J0885: This list **does** require a dual diagnosis.

The following ICD-9-CM codes require **modifier EA** and a dual diagnosis: 285.3 **and** one of the following must be billed together:

140.0-149.9	150.0-159.9	160.0-165.9
170.0-176.9	179-189.9	190.0-199.2
200.00-200.88	201.00-201.98	202.00-202.98
203.00-203.82	204.00-204.92	209.00-209.03
209.10-209.17	209.20-209.29	209.30- 209.36
209.70-209.79	230.0-234.9	235.0-235.9
236.0-236.99	237.0-237.9	238.0, 238.1
238.2	238.3	238.4
238.5	238.6	238.8
238.9	or 239.0-239.9	

AJ0881: Erythropoiesis stimulating agents – clarification on coding (continued)

J0885: This list **does not** require a dual diagnosis

The following ICD-9-CM codes require the EC modifier:

238.71 238.72 238.73 238.74
238.75 238.76 or 273.3.

J0885: This list **does** require a dual diagnosis.

The following ICD-9-CM codes require **modifier EC** and a dual diagnosis (*):285.21* **and** one of the following must be billed together:

403.01* 403.11* 403.91* 404.02*
404.03* 404.12* 404.13* 404.92*
404.93* 585.1* 585.2* 585.3*
585.4* 585.5* or 585.9*.

ICD-9-CM 285.29* or 285.9* **and** one of the following must be billed together:

042* 070.54* 070.70* 714.0*
or V07.8*.

Information found in the coding guidelines attachment:

As of January 1, 2008, the following are nationally noncovered indications for non-ESRD ESAs that report ESA modifier EC. These are not to be reported with any other ESA modifier. Because no specific ICD-9-CM code exists for these indications listed, FCSO will identify these noncovered conditions with ICD-9-CM code **V49.89.** This will indicate the ESA was given for a nationally noncovered condition as identified in business requirement 5818.1.1 of change request (CR) 5818.

- Any anemia in cancer or cancer treatments patients due to bone marrow fibrosis
- Anemia of cancer not related to cancer treatment
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatments if patients have uncontrolled hypertension

Please see end of article for additional list of nationally noncovered indications identified in the NCD for non-ESRD ESA use.

Summary of non-ESRD ESA coverage based on CR 5818 and 5699 implemented on April 7, 2008

Effective January 1, 2008, all claims reporting non- ESRD ESAs (HCPCS codes J0881 and J0885) are required to report one of the following modifiers: (based on CR 5699)

- EA: ESA, anemia, chemo induced
- EB: ESA anemia, radio-induced
- EC: ESA anemia, non-chemo/radio

Modifier EA should only be reported when the ESA is being given for anemia resulting from myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia that is not related to the administration of chemotherapy for one of the listed covered cancer conditions is **noncovered per the NCD**. Therefore it is inappropriate to append **modifier EA** to those ESA claims. These ESA administrations should be identified with ICD-9-CM code V49.89 (as instructed in the coding guideline of the LCD) and **modifier EC** should be appended.

Modifier EC should only be reported for those covered indications outlined in the LCD under "ICD-9 codes that support medical necessity" for HCPCS codes J0881 and J0885 where the anemia being treated is non-chemo/radio induced. The provider must also append **modifier EC** for those nationally noncovered conditions outlined in the NCD and the coding guidelines of the LCD. The noncovered ICD-9-CM codes that correspond to the nationally noncovered indications are noted in the coding guidelines. If one of the noncovered ICD-9-CM codes and **modifier EC** are billed with HCPCS codes J0881 or J0885, the ESA will be denied.

Modifier EB is noncovered. If billed with an ESA the claim will be denied.

Effective January 1, 2008, all claims reporting ESAs J0881, J0882, J0885, J0886 or Q4081 must report the most recent hemoglobin or hematocrit readings. For non-ESRD ESAs (HCPCS codes J0881 and J0885) reporting **modifier EA** (anemia that is related chemotherapy), the hemoglobin or hematocrit are required to be below a certain level in order for the service to be medically necessary. Contractors are instructed, per CR 5818 to deny ESA services that report HCPCS codes J0881 or J0885 with modifier EA when **Hgb is > 10.0g/L or the Hct is > 30 percent.** There is no exception to this requirement and there is no four-week window at initiation where providers can report a level above 10.0 g/L or 30 percent and have the service paid. The entire discussion surrounding ESA administration for cancer conditions is outlined in the LCD and NCD 110.21.

Additional noncovered indications as identified in NCD 110.21 for non-ESRD ESA use are listed below. The ESA services for HCPCS codes J0881 and J0885 when reported with modifier EC will be denied when the following ICD-9-CM codes are reported:

- Any anemia in cancer or cancer treatment patients due to folate deficiency 281.2
- B-12 deficiency 281.1, 281.3
- Iron deficiency 280.0-280.9
- Hemolysis 282.0, 282.2, 282.9, 283.0, 283.10, 283.19, 283.2, 283.9
- Bleeding 280.0, 285.1
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) 205.00-205.21, 205.80-205.91
- Erythroid cancers (207.00-207.81)

AJ0881: Erythropoiesis stimulating agents – clarification on coding (continued)

Resources for information on ESA coverage

The complete NCD may be accessed in Section 110.21 of Publication (Pub.) 100-03, *Medicare National Coverage Determinations (NCD) Manual*, and claim processing instructions may be accessed in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 17, sections 80.8-80.12 and through the following link:

http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=110.21&ncd_version=1&basket=ncd%3A110%2E21%3A1%3AErythropoiesis+Stimulating+Agents+%28ESAs%29+in+Cancer+and+Related+Neoplastic+Conditions

CR 5818, transmittal 80 and 1413, dated January 14, 2008, may be accessed through the following links:

http://www.cms.hhs.gov/transmittals/downloads/R1413CP.pdf

http://www.cms.hhs.gov/transmittals/downloads/R80NCD.pdf

CR 5699, transmittal 1412, dated January 11, 2008, may be accessed through the following link:

http://www.cms.hhs.gov/transmittals/downloads/R1412CP.pdf

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. ❖

Signature requirement clari cation

First Coast Service Options Inc. (FCSO) has seen a significant increase in the number of comprehensive error rate testing (CERT) errors related to the lack of a legible signature in medical record documentation. The CERT contractor confirmed that the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have clarified that providers of Medicare services must comply with the signature legibility requirements outlined in the Internet-only manual, Publication 100-08, Chapter 3, Section 3.4.1.1 B:

> *Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.* (The only exception is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.)

The legible identifier (signature) requirement applies to documentation for any service performed and billed to Medicare. The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, operative reports, orders, test findings, etc., is to support that the services have been accurately and completely documented, reviewed and authenticated.

The CERT contractor is rigorously enforcing the CMS requirement that all medical records subject to medical review must include a legible identifier (signature). Documentation that is submitted with an illegible signature, initials, an unauthenticated electronic signature, no signature, or an unsigned typewritten signature will be denied and assigned a CERT error. This error will produce an overpayment and a subsequent recoupment of funds.

Physicians, nonphysician practitioners, and other health care providers who bill Medicare contractors must remember:

- A legible signature is required on all medical records subject to medical review.
- Prior to submission for medical review, every medical record should be audited to ensure that the beneficiary's name, the date of service, and the signature of the provider of services are on the records.
- If the provider's signature is illegible, a signature legend/log identifying the author associated with the illegible signature or initials should be submitted with the records. This applies to records submitted to any Medicare contractor, including the Medicare administrative contractor (MAC) and the CERT contractor.
- Electronic signatures should be safeguarded against misuse (such as password protected) and should be easily identifiable as electronic, rather than typewritten, signatures.

Providers should ensure that their offices and/or billing departments are aware of these guidelines.

Find LCDs faster on our new medical coverage page

Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before – try it today. *http://medicare.fcso.com/Landing/139800.asp*.

HOSPITAL SERVICES

Coverage of inpatient rehabilitation services

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

Provider types affected

Inpatient rehabilitation facilities (IRFs) billing Medicare contractors (fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for inpatient rehabilitation services provided to Medicare beneficiaries are affected by change request (CR) 6699

Provider action needed STOP – impact to you

This article is based on CR 6699, which implements new instructions for coverage of inpatient rehabilitation services provided to Medicare beneficiaries.

CAUTION – what you need to know

CR 6699 issues new instructions to replace the existing instructions found in Section 110 of the *Medicare Benefit Policy Manual*. These new instructions are consistent with the new IRF coverage requirements adopted by the Centers for Medicare & Medicaid Services (CMS) in the fiscal year (FY) 2010 final rule.

These new policies apply to discharges from IRFs occurring on or after January 1, 2010.

GO – what you need to do

IRFs need to be aware of these policies and also need to know that existing Medicare contractor local coverage determination policies for inpatient rehabilitation facility admissions are no longer effective with discharges occurring on or after January 1, 2010.

Background

CMS adopted new IRF coverage requirements to reflect changes that have occurred in the practice of medicine during the past 25 years and the implementation of the IRF prospective payment system (PPS). See the FY 2010 final rule (74 FR 39762 (August 7, 2009) on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-18616.pdf*.

In light of adopting the new coverage requirements (effective for IRF discharges occurring on or after January 1, 2010), a notice has been issued to rescind Health Care Financing Administration ruling 85-2 (HCFAR 85-2) when the new coverage requirements take effect.

Section 110 of *the Medicare Benefit Policy Manual* (MBPM) was originally based upon the provisions found in HCFAR 85-2. Therefore, the purpose of CR 6699 is to issue new instructions that are consistent with the new IRF coverage requirements adopted in the FY 2010 final rule.

The manual revision attached to CR 6699 replaces Section 110 of the MBPM with new instructions that describe coverage for inpatient rehabilitation services provided in IRFs. These new instructions are based on recent regulatory changes, which may be found on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-18616.pdf*.

Under the new coverage policies, the decision to admit the beneficiary to the IRF is the key to determining whether the admission is reasonable and necessary. Therefore, the new instructions (which are provided as an attachment to CR 6699) are detailed below and cover the following subjects:

- Documentation Requirements
- Required Preadmission Screening
- Required Post-Admission Physician Evaluation
- Required Individualized Overall Plan of Care
- Required Admission Orders
- Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Inpatient Rehabilitation Facility Medical Necessity Criteria
- Multiple Therapy Disciplines
- Intensive Level of Rehabilitation Services
- Ability to Actively Participate in Intensive Rehabilitation Program
- Physician Supervision
- Interdisciplinary Team Approach to the Delivery of Care
- Definition of Measurable Improvement.

Inpatient rehabilitation facility services

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who, therefore, are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Coverage of inpatient rehabilitation services (continued)

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) if the patient meets all of the requirements outlined in 42 CFR 412.622(a)(3), (4), and (5), as interpreted in Chapter 1, Section 110 of the *Medicare Benefit Policy Manual*, which is attached to CR 6699. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.23(b)(2)(iii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, please see Chapter 15, Sections 220 and 230 of the Medicare Benefit Policy Manual. That manual is on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Documentation requirements

Medicare contractors must consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

Required preadmission screening

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function, expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from a referring hospital, the preadmission screening may be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff in the IRF.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which is expected to include all of the required elements described in section 110.1.1 of the MBPM, as attached to CR 6699. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified (to the extent possible under state licensure laws and requirements) and qualified to perform the evaluation within their scopes of practice and training. Although clinical personnel are required to evaluate the preadmission screening information, each IRF may determine its own processes for collecting and compiling the preadmission screening information.

The "rehabilitation physician" need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation.

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient's medical record at the IRF.

"Trial" IRF admissions, during which patients were sometimes admitted to IRFs for three to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary.

Required post-admission physician evaluation

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician. The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care. The post-admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented history and physical examination, as well

Coverage of inpatient rehabilitation services (continued)

as a review of the patient's prior and current medical and functional conditions and comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record at the IRF.

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in an intensive rehabilitation therapy program on admission to the IRF, but the patient is only able to tolerate a less intensive therapy program on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient.

Instead, the reason for the temporary change must be noted in the patient's medical record at the IRF.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either (for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program). If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the third day following the patient's admission to the IRF are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim, Medicare authorizes its contractors to permit the IRF claim to be paid at the appropriate case-mix group (CMG) for IRF patient stays of three days or less.

Required individualized overall plan of care

Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record at the IRF.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first four days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF. IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

Required admission orders

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a rehabilitation physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF.

Required inpatient rehabilitation facility patient assessment instrument (IRF-PAI)

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record at the IRF (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

Inpatient rehabilitation facility medical necessity criteria

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-

Coverage of inpatient rehabilitation services (continued)

language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2 of the MBPM. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three hours of therapy per day at least five days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven consecutive day period, beginning with the date of admission to the IRF.
3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment and if such improvement can be expected to be made within a prescribed period of time.
4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

Multiple therapy disciplines

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care.

Intensive level of rehabilitation services

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of rehabilitation services can be reflected in various ways, the generally accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least three hours per day at least five days per week.

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a seven-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of four hours of therapy three days per week and 1 ½ hours of therapy on two (or more) other days per week in order to accommodate his or her chemotherapy schedule. Therefore, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a seven-consecutve day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

Brief exceptions policy

While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in the intensive therapy program for a brief period not to exceed three consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's IRF medical record. If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

Coverage of inpatient rehabilitation services (continued)

Ability to actively participate in intensive rehabilitation therapy program

The information in the patient's IRF medical record (especially the required documentation described in Section 110.1 of the MBPM) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program.

Physician supervision

A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is generally demonstrated by documented face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least three days per week throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than three days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician with the necessary training and experience to make these assessments at least three times per week. The required rehabilitation physician visits should be documented in the patient's medical record at the IRF.

Interdisciplinary team approach to the delivery of care

An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. The complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals.

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician with specialized training and experience in rehabilitation services
- A registered nurse with specialized training or experience in rehabilitation
- A social worker or a case manager (or both)
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions, regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals
- Considering possible resolutions to any problems that could impede progress towards the goals
- Reassessing the validity of the rehabilitation goals previously established
- Monitoring and revising the treatment plan, as needed.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF.

Definition of measurable improvement

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and

Coverage of inpatient rehabilitation services (continued)

degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services and an inter-disciplinary team approach to care. Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment.

Additional information

The official instruction, CR 6699, issued to your FI or MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R112BP.pdf*.

Attached to that CR are the complete sections of Chapter 1 that have been added to the Medicare Benefit Policy Manual.

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

MLN Matters® Number: MM6699
Related Change Request (CR) Number: 6699
Related CR Release Date: October 23, 2009
Related CR Transmittal Number: R112BP
Effective Date: IRF Discharges on or after January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-02, Transmittal 112, CR 6699

Revised October 2009 quarterly provider specific file update

The Centers for Medicare & Medicaid Services (CMS) has notified contractors that the October 2009 quarterly provider specific file (PSF) **statistical analysis software (SAS)** data files, and the quarterly PSF **text** data files have been revised and are now available for the latest version to be downloading.

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

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

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

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

Source: CMS PERL 200910-29

Hospital outpatient department payment information for value-driven health care

To support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions, the U.S. Department of Health & Human Services is making cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2007 and 2008 about the payments made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

The hospital information is posted on the Hospital Compare Web site where it may be viewed along with hospital quality information. The Hospital Compare Web site may be found at *http://www.medicare.gov*.

On August 28, 2009, Medicare posted an update to the ASC data. An update to the physician payment data was posted on September 25, 2009, and an update to the hospital outpatient department data was posted on October 14, 2009. The information is being displayed in the same format as in previous years, updated with calendar year (CY) 2008 data. The posting updates may be found at *http://www.cms.hhs.gov/HealthCareConInit/*. ❖

Source: CMS PERL 200910-22

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes

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 MM6634 to show the correct national labor share operating rates for a wage index > 1 with a **FULL and REDUCED market basket** in the table published on pages 25-26. The rates previously shown were incorrect, although the correct rates were shown in change request (CR) 6634. All other information remains the same. The *MLN Matters* article MM6634 was published in the September 2009 *Medicare A Bulletin* (pages 25-40).

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6634 which outlines changes for inpatient prospective payment system (IPPS) and long-term care hospitals (LTCHs) for fiscal year (FY) 2010. The policy changes for FY 2010 appeared in the *Federal Register* on August 27, 2009. All items covered in CR 6634 are effective for hospital discharges occurring on or after October 1, 2009, unless otherwise noted. CR 6634 also addresses changes to Medicare severity-diagnosis related groups (MS-DRGs) and ICD-9-CM coding that affects the inpatient psychiatric facility (IPF) PPS. The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment, effective October 1, 2009. The IPF PPS rate changes occurred on July 1, 2009 and are discussed in *MLN Matters*® article MM6461 on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6461.pdf*.

Be sure your billing personnel are aware of these changes.

Background

The key changes conveyed in CR 6634 are as follows:

ICD-9-CM changes

The ICD-9-CM coding changes are effective October 1, 2009. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 27, 2009, *Federal Register*. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 27, 2009, *Federal Register* notice is available on the Internet at *http://www.access.gpo.gov/su_docs/fedreg/frcont09.html*.

The GROUPER contractor, 3M-HIS, introduced a new MS-DRG GROUPER, Version 27.0, software package effective for discharges on or after October 1, 2009. The GROUPER 27.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare code editor (MCE) 26.0 which is also developed by 3M-HIS, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2009.

The inpatient prospective payment system FY 2010 update

The FY 2010 IPPS PRICER is for discharges occurring on or after October 1, 2009. It includes all pricing files for FY 2005 through FY 2010 to process bills with discharge dates on or after October 1, 2004.

FY 2009 inpatient prospective payment system rates

Standardized amount update factor	1.021 1.001 (for hospitals that do not submit quality data)
Hospital specific update factor	1.021 1.001 (for hospitals that do not submit quality data)
Common fixed loss cost outlier threshold	$23,140.00
Federal capital rate	$429.26
Puerto Rico capital rate	$203.56
Outlier offset-operating national	0.948994
Outlier offset-operating Puerto Rico	0.957524
IME formula (no change for FY 2010)	1.35 x [(1 + resident to bed ratio).405 – 1]
MDH/SCH budget neutrality factor	0.997941

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Operating rates with FULL market basket

	Wage index > 1		Wage index ≤ than 1	
	Labor share	Non-labor share	Labor share	Non-labor share
National	$3,593.52	$1,629.62	$3,238.35	$1,984.79
Puerto Rico national	$3,593.52	$1,629.62	$3,238.35	$1,984.79
Puerto Rico specific	$1,542.72	$941.52	$1,540.23	$944.01

Rates with REDUCED Market Basket

	Wage index > 1		Wage index ≤ than 1	
	Labor share	Non-labor share	Labor share	Non-labor share
National	$3,523.13	$1,597.70	$3,174.91	$1,945.92
Puerto Rico national	$3,523.13	$1,597.70	$3,174.91	$1,945.92
Puerto Rico specific	$1,542.72	$941.52	$1,540.23	$944.01

Cost-of-living adjustment (COLA) factors: Alaska and Hawaii hospitals

Area	COLA factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25 (no change for FY 2010)

Note: There are no COLA changes for Hawaii in FY 2010.

Postacute transfer policy

See Table 5 of the IPPS final rule for a listing of all postacute and special postacute MS-DRGs.

New technology add-on payments

The following items are eligible for new-technology add-on payments in FY 2010:

- **Total artificial heart (TAH-t)** – Effective in FY 2009 and through FY 2010, the new technology add-on payment for the TAH-t is triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code V70.7 (Examination of participant in clinical trial). The maximum add-on payment is $53,000 per case.
- **Spiration IBV** – Effective for FY 2010, cases involving the Spiration® IBV® that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 163, 164 and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49. The maximum add on payment for the Spiration® IBV® is $3,437.50 per case.

If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount will be paid that is equal to the lesser of 50 percent of the costs of the new medical service/technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

State rural floor budget neutrality adjustment factors

The FY 2009 IPPS PRICER included a new PRICER table, "State Rural Floor Budget Neutrality Adjustment Factors", due to new regulations for the wage index, at 42 CFR 412.64(e)(4), that were implemented in the FY 2009 IPPS final rule (73 FR 48570). "Specifically, CMS must make an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105-33) and the imputed floor under Section 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected. Beginning October 1, 2008, such payments will transition from a nationwide adjustment, with a statewide adjustment fully in place by October 1, 2011."

The table in Attachment A of CR 6634 lists the blended overall rural floor budget neutral factors, for FY 2010, that are to be applied onto the wage index (based on the providers' geographic state location). CR 6634 is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1815CP.pdf*.

The wage table loaded for the FY 2010 PRICER contains wage index values **prior** to the application of the blended overall rural floor budget neutrality factors. The PRICER software is applying the budget neutrality factors from Attachment A to the wage index within the PRICER payment logic. The wage index tables printed in the FY 2010 *Federal Register* final rule notice already have the blended overall rural floor budget neutrality factors applied. To confirm the wage index PRICER used in calculating payments with the wage index printed in the *Federal*

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Register, you must take the wage index from PRICER and multiply it by the appropriate factor from Attachment A. Attachment A of CR 6634 is also duplicated at the end of this article.

Expiration of Section 508 reclassifications

Section 508 of the 2003 Medicare Modernization Act will expire on October 1, 2009. The provider specific file (PSF) will be adjusted accordingly for hospitals previously designated as a Section 508 hospital.

Section 505 hospital (out-commuting adjustment)

Attachment B of CR 6634 shows the IPPS providers that will be receiving a "special" wage index for FY 2010 (i.e., receives an out-commuting adjustment under section 505 of the MMA). For any provider with a special wage index from FY 2009, FIs and A/B MACs shall remove that special wage index, by entering zeros in the field unless they receive a new special wage index as listed in Attachment B.

Low volume hospitals

Hospitals considered low volume shall receive a 25 percent bonus to the operating final payment. To be considered "low volume" the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify their FI or A/B MAC if they believe they are a low volume hospital. The low volume hospital status should be re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at on the Internet *http://www.qualitynet.org/pqri*.

This Web site is expected to be updated in September 2010. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site. Hospitals not receiving the 2.0 percent RHQDAPU annual payment update for FY 2010 s are listed in Attachment C of this CR.

For new hospitals, FIs and A/B MACs will provide information to the quality improvement organization (QIO) as soon as possible so that the QIO can enter the provider information into the program resource system and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the hospital quality initiative.

Capital inpatient prospective payment system adjustment for indirect medical education (IME)

In the FY 2008 IPPS final rule, the CMS adopted a policy to phase-out the capital IPPS teaching adjustment. For FY 2009, hospitals would receive 50 percent of the IME adjustment provided under the current formula. Section 4301(b) of the American Recovery and Reinvestment Act (ARRA) removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009, (per CR 6444 issued on March 27, 2009).

The capital teaching adjustment is no longer being eliminated for FY 2010. Therefore, the full capital IME teaching adjustment is restored for FY 2010 and will be determined under Section 412.322(b).

Capital PPS payment for providers redesignated under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(II)(D)(3) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties (commonly referred to as "counties") adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these "Lugar counties" (commonly referred to as "Lugar hospitals") are deemed to be located in an urban area and receive the federal payment amount for the urban area to which they are redesignated. To ensure these "Lugar hospitals" are paid correctly under the capital PPS, FIs and A/B MACs must enter the urban core based statistical area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF.

Note: This may be different from the urban CBSA in the wage index CBSA field on the PSF for "Lugar hospitals" that are reclassified for wage-index purposes. However, if a "Lugar hospital" declines its redesignation as urban in order to retain its rural status, FIs and A/B MACs must enter the rural CBSA (two-digit state code) in the standardized amount CBSA field on the PSF rather than the urban CBSA from the chart to ensure correct payment under the capital PPS.

Treatment of certain urban hospitals reclassified as rural hospitals under Section 412.103 for purposes of capital PPS payments

Hospitals reclassified as rural under Section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)). Similarly, the geographic adjustment factor (GAF) for hospitals reclassified as rural under Section 412.103 is determined from the applicable statewide rural wage index.

Medicare-dependent hospitals (MDHs): Budget neutrality adjustment factors for FY 2002-based hospital-specific (HSP) rate

Effective FY 2010, CMS is correcting the MDH FY 2002 HSP rate calculation to include the cumulative budget neutrality adjustment factor for FYs 1993 through 2002 in addition to the budget neutrality adjustment factors for FYs 2003 forward. Section 5003(b) of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) allows MDHs to rebase their HSP rates using data from their FY 2002 cost report if this results in a payment increase.

To implement this provision, CMS issued Transmittal 1067 (Change Request 5276 dated September 25, 2006) with instructions to FIs to determine and update the FY 2002 HSP rate for qualifying MDHs. To calculate an MDH's FY 2002 HSP rate and update it to FY 2007, the instructions directed FIs to apply cumulative budget neutrality adjustment factors for FYs 2003 through 2007. However, the instructions did not include the cumulative budget neutrality adjustment factor to account for changes in the DRGs from FYs 1993 through 2002.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

To correct for this, FIs and A/B MACs must adjust any FY 2002 HSP rates of MDHs currently in the PSF by applying a factor of 0.982557, which is calculated as the product of the following budget neutrality adjustment factors from FYs 1993 through 2002:

0.999851 for FY 1993

0.999003 for FY 1994

0.998050 for FY 1995

0.999306 for FY 1996

0.998703 for FY 1997

0.997731 for FY 1998

0.998978 for FY 1999

0.997808 for FY 2000

0.997174 for FY 2001

0.995821 for FY 2002.

The inflation update from FYs 2002 through 2007 and the cumulative budget neutrality adjustment factors for FYs 2003 through 2007 should have already been applied as specified in Transmittal 1067 (change request 5276 dated September 25, 2006).

Section 1886(d)(5)(G) of the Act provides that the HSP rate for MDHs is based on FY 1982, FY 1987 or FY 2002 costs per discharge, whichever of these HSP rates is the highest.

After the FY 2002 HSP rates are adjusted as described above, FIs and A/B MACS should verify that the FY 2002 HSP rate is still the highest of the applicable based years (that is, FY 1982, FY 1987 or FY 2002). In those cases where a MDH's FY 2002 HSP rate is no longer higher than its FY 1982 or FY 1987 HSP rate, the applicable HSP rate (FY 1982 or FY 1987) updated to FY 2007 dollars shall be entered in to the PSF effective October 1, 2009.

For FY 1982 or FY 1987 HSP rates that had previously been updated to FY 2000 dollars (that is, a MDH's HSP rate prior to the implementation of the rebasing to FY 2002 provided for by section 5003(b) of the DRA) before entering it in the PSF with an effective date of October 1, 2009, the FY 1982 or FY 1987 HSP shall be updated from FY 2000 dollars to FY 2007 dollars by applying an update factor of 1.233973509, which is computed as the product of the FY 2001 update factor of 1.034, the FY 2001 budget neutrality factor of 0.997174, the FY 2002 update factor of 1.0275, the FY 2002 budget neutrality factor of 0.995821 and the update and inflation factors for FYs 2003 through 2007 listed above.

As directed above, FIs and A/B MACs shall adjust the FY 2002 HSP rates of MDHs currently in the PSF and enter it that amount in the PSF with an effective date of October 1, 2009. This adjustment to the FY 2002 HSP rates of MDHs is not to be applied in determining payments for discharges occurring prior to October 1, 2009. For purposes of the settlement of MDH cost reports that include discharges that occurred from October 1, 2006, through September 30, 2009, FIs and A/B MACs shall use the originally computed, that is, the FY 2002 HSP rates of MDHs that is currently in the PSF.

The long-term care hospital PPS rate year 2010 update

RY 2010 LTCH PPS rates

Federal rate	$39,896.65
High cost outlier fixed-loss amount	$18,425.00
Labor share	75.779 percent
Non-labor share	24.221 percent

MS-LTC-DRG update

The LTCH PPS PRICER has been updated with the Version 27.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2009, and on or before September 30, 2010.

Cost-of-living adjustment (COLA) update for LTCH PPS

LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. See the table below for the updated COLAs implemented as part of the RY 2010 LTCH PPS Final Rule, which are effective for discharges occurring on or after October 1, 2009.

Area	COLA factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25 (no change from RY 2009)
Hawaii:	
City and County of Honolulu	1.25 (no change from RY 2009)
County of Hawaii	1.18
County of Kauai	1.25 (no change from RY 2009)
County of Maui and County of Kalawao	1.25 (no change from RY 2009)

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Core-based statistical area (CBSA)-based labor market definition changes

There are several revisions to the core-based statistical area (CBSA)-based labor market definitions used under the LTCH PPS, which are the basis of the wage index adjustment, effective October 1, 2009. The following changes affect the CBSA codes used for the wage index assignment under the LTCH PPS:

- For any LTCHs currently located in CBSA 42260, the CBSA code on the PSF will need to be changed to 14660 (from 42260) effective October 1, 2009, due to a title change for that CBSA.
- For any LTCHs currently located in Bollinger County or Cape Girardeau County, Missouri, the CBSA code on the PSF will need to be changed to 16020 (from the rural two-digit state code 26) effective October 1, 2009, due to the creation of a new urban CBSA.
- For any LTCHs currently located in Alexander County, Illinois, the CBSA code on the PSF will need to be changed to 16020 (from the rural two-digit state code 14) effective October 1, 2009, due to the creation of a new urban CBSA.
- For any LTCHs currently located in Geary County, Pottawatomie County or Riley County, Kansas, the CBSA code on the PSF will need to be changed to 31740 (from the rural two-digit state code 17) effective October 1, 2009, due to the creation of a new urban CBSA.
- For any LTCHs currently located in Blue Earth County or Nicollet County, Minnesota, the CBSA code on the PSF will need to be changed to 31860 (from the rural two-digit state code 24) effective October 1, 2009, due to the creation of a new urban CBSA.

Changes to LTCH PPS payment policy made by the American Recovery and Reinvestment Act (ARRA) of 2009

The February 17, 2009, enactment of the ARRA, made changes to two provisions of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007, the three-year moratoria on the establishment of new LTCHs and LTCH satellites and on the increase in beds in existing LTCHs and LTCH satellites and revisions to the percentage threshold payment adjustment for LTCHs and LTCH satellites. (These MMSEA changes, which were finalized in the RY 2010 LTCH PPS final rule, were addressed, respectively, in CR 6172, issued on December 19, 2008, and CR 5955, issued on March 7, 2008.) The ARRA added an additional exception to the moratorium on the increase in beds in existing LTCHs or LTCH satellites if an existing LTCH located in a state that required a certificate of need (CON), had obtained a CON for a bed increase that was issued on or after April 1, 2005, and before December 29, 2007.

Additionally, the ARRA amended the MMSEA provision regarding the percentage threshold payment adjustment. (These ARRA changes were implemented in an interim final rule with comment period which was published with the RY 2010 LTCH PPS final rule.) Specifically, an additional category of LTCH satellites, "grandfathered" satellites (described at 42 CFR Section 412.22(h)(3)(i)) was added to those LTCH HwHs and satellites identified by the MMSEA as "applicable" for the three-year percentage threshold increase. The ARRA also changed the effective date of all of MMSEA changes from the effective date of MMSEA (December 29, 2009) to July 1, 2007 or October 1, 2007, based upon the particular provision.

The inpatient psychiatric facility (IPF) PPS update

DRG adjustment update

The IPF PPS has DRG specific adjustments for MS-DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of CMS's identified psychiatric DRGs, the IPF will still receive the federal per diem base rate and all other applicable adjustments.

The IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and MS-DRG classification system, in order to maintain consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2010 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. This table is only a listing of FY 2010 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs. When coded as a principal diagnosis, these codes receive the correlating MS-DRG adjustment.

Diagnosis code	MS-DRG descriptions	MS-DRG
438.13	Late effects of cerebrovascular disease, dysarthria	056, 057
438.14	Late effects of cerebrovascular disease, fluency disorder	056, 057
799.21	Nervousness	880
799.22	Irritability	880
799.23	Impulsiveness	882

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Diagnosis code	MS-DRG descriptions	MS-DRG
799.24	Emotional lability	883
799.25	Demoralization and apathy	880
799.29	Other signs and symptoms involving emotional state	880

The following table lists the FY 2010 **invalid** ICD-9-CM diagnosis code that is no longer applicable for the DRG adjustment.

Diagnosis code	MS-DRG description	MS-DRG
799.2	Nervousness	880

Since CMS does not plan to update the regression analysis until the IPF PPS data is analyzed, the MS-DRG adjustment factors, shown in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 3, Section 190.5.1 are effective October 1, 2009, and will continue to be paid for RY 2010.

Comorbidity adjustment update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes for certain comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to eight additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

The IPF PPS utilizes the MS-severity DRG coding system, in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. CMS is currently using the FY 2010 GROUPER, version 27.0 which is effective for discharges occurring on or after October 1, 2009.

The following three tables below list the FY 2010 new, revised and invalid ICD-9-CM diagnosis codes, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2010 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

The table below lists the FY 2010 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table lists only the FY 2010 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. The RY 2010 IPF PRICER will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

Diagnosis code	Description	Comorbidity category
209.31	Merkel cell carcinoma of the face	Oncology treatment
209.32	Merkel cell carcinoma of the scalp and neck	Oncology treatment
209.33	Merkel cell carcinoma of the upper limb	Oncology treatment
209.34	Merkel cell carcinoma of the lower limb	Oncology treatment
209.35	Merkel cell carcinoma of the trunk	Oncology treatment
209.36	Merkel cell carcinoma of other sites	Oncology treatment
209.70	Secondary neuroendocrine tumor, unspecified site	Oncology treatment
209.71	Secondary neuroendocrine tumor of distant lymph nodes	Oncology treatment
209.72	Secondary neuroendocrine tumor of liver	Oncology treatment
209.73	Secondary neuroendocrine tumor of bone	Oncology treatment
209.74	Secondary neuroendocrine tumor of peritoneum	Oncology treatment
209.75	Secondary Merkel cell carcinoma	Oncology treatment
209.79	Secondary neuroendocrine tumor of other sites	Oncology treatment
239.81	Neoplasms of unspecified nature, retina and choroid	Oncology treatment
239.89	Neoplasms of unspecified nature, other specified sites	Oncology treatment
969.00	Poisoning by antidepressant, unspecified	Poisoning

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Diagnosis code	Description	Comorbidity category
969.01	Poisoning by monoamine oxidase inhibitors	Poisoning
969.02	Poisoning by selective serotonin and norepinephrine reuptake inhibitors	Poisoning
969.03	Poisoning by selective serotonin reuptake inhibitors	Poisoning
969.04	Poisoning by tetracyclic antidepressants	Poisoning
969.05	Poisoning by tricyclic antidepressants	Poisoning
969.09	Poisoning by other antidepressants	Poisoning
969.70	Poisoning by psychostimulant, unspecified	Poisoning
969.71	Poisoning by caffeine	Poisoning
969.72	Poisoning by amphetamines	Poisoning
969.73	Poisoning by methylphenidate	Poisoning
969.79	Poisoning by other psychostimulants	Poisoning

The table below lists the FY 2010 **revised** ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2010 revised codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

Diagnosis code	Description	Comborbidity category
584.5	Acute kidney failure with lesion of tubular necrosis	Renal failure, acute
584.6	Acute kidney failure with lesion of renal cortical necrosis	Renal failure, acute
584.7	Acute kidney failure with lesion of renal medullary [papillary] necrosis	Renal failure, acute
584.8	Acute kidney failure with other specified pathological lesion in kidney	Renal failure, acute
584.9	Acute kidney failure, unspecified	Renal failure, acute
639.3	Kidney failure following abortion and ectopic and molar pregnancies	Renal failure, acute
669.32	Acute kidney failure following labor and delivery, delivered, with mention of postpartum complication	Renal failure, acute
669.34	Acute kidney failure following labor and delivery, postpartum condition or complication	Renal failure, acute

The table below lists the **invalid** ICD-9-CM codes no longer applicable for the comorbidity adjustment. The RY 2010 IPF PRICER will be updated to remove these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

Diagnosis code	Description	Comorbidity category
239.8	Neoplasm of unspecified nature of other specified sites	Oncology treatment
969.0	Poisoning by antidepressants	Poisoning
969.7	Poisoning by psychostimulants	Poisoning

The seventeen comorbidity categories for which CMS is providing an adjustment, their respective codes, including the new FY 2010 ICD codes, and their respective adjustment factors, are listed below in the following table.

Description of comorbidity	ICD-9-CM code	Adjustment factor
Developmental disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation factor deficits	2860 through 2864	1.13
Tracheostomy	51900 through 51909 and V440	1.06
Renal failure, acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Description of comorbidity	ICD-9-CM code	Adjustment factor
Renal failure, chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V4511, V4512, V560, V561, and V562	1.11
Oncology treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled diabetes-mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe protein calorie malnutrition	260 through 262	1.13
Eating and conduct disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or alcohol induced mental disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic obstructive pulmonary disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial openings – digestive and urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe musculoskeletal and connective tissue diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

Billing wrong surgical or other invasive procedures performed on a patient, surgical or other invasive procedures performed on the wrong body part, and surgical or other invasive procedures performed on the wrong patient (related CR 6405)

Effective date: Discharges on or after October 1, 2009

CMS internally generated a request for a national coverage analysis (NCA) to establish national coverage determinations (NCDs) addressing Medicare coverage of wrong surgical or other invasive procedures performed on a patient, surgical or other invasive procedures performed on the wrong body part, and surgical or other invasive procedures performed on the wrong patient. Information regarding these NCDs may be found in Publication (Pub.) 100-03, Chapter 1, Sections 140.6, 140.7, and 140.8, respectively.

The CMS previously issued CR 6405 to provide instruction to hospitals on how to bill erroneous surgeries. It explained that, for inpatient claims, hospitals are required to submit a no-pay claim (type of bill 110) when the erroneous surgery related to the NCD is reported. However, if there are also covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the noncovered services/procedures as a no-pay claim.

Additionally, CR 6405 instructed hospitals to report surgical error indicators in the remarks field of the noncovered TOB 110. However, effective for discharges on or after October 1, 2009, hospitals are not to report the surgical error indicator as was previously instructed. Instead, the noncovered TOB 110 must have one of the following ICD-9-CM diagnosis code reported in diagnosis position 2-9:

E876.5 Performance of wrong operation (procedure) on correct patient (existing code)

E876.6 Performance of operation (procedure) on patient not scheduled for surgery

E876.7 Performance of correct operation (procedure) on wrong side/body part

Note: The above codes shall not be reported in the external cause of injury (E-code) field.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Additional Information

For a one-stop resource Web page focused on the informational needs and interests of Medicare fee-for-service (FFS) hospitals, go to the Hospital Center on the CMS Web site at *http://www.cms.hhs.gov/Center/Hospital.asp*.

The LTCH PPS regulations and notices are available on the CMS Web site at *http://www.cms.hhs.gov/longtermcarehospitalpps/*.

The IPF PPS regulations and notices are available on the CMS Web site at *http://www.cms.hhs.gov/inpatientPsychFacilPPS/*.

The official instruction, CR 6634, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1816CP.pdf*.

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

MLN Matters® Number: MM6634 – Revised
Related Change Request (CR) Number: 6634
Related CR Release Date: September 17, 2009
Effective Date: Discharges on or after October 1, 2009
Related CR Transmittal Number: R1816CP
Implementation Date: October 5, 2009
Source: CMS Pub. 100-04, Transmittal 1816, CR 6634

Rural floor budget neutrality factors for acute care hospitals – Fiscal year 2010

CR 6634 Attachment A

The rural floor budget neutrality adjustment factor in this table reflects a blend of the state factor (weighted at 50 percent) and the nationwide factor (50 percent).

State	Rural floor budget neutrality adjustment factor
Alabama	0.99835
Alaska	0.99835
Arizona	0.99835
Arkansas	0.99835
California	0.99415
Colorado	0.99413
Connecticut	0.97887
Delaware	0.99835
Washington, D.C.	0.99835
Florida	0.99755
Georgia	0.99835
Hawaii	0.99835
Idaho	0.99835
Illinois	0.99835
Indiana	0.99813
Iowa	0.99767
Kansas	0.99829
Kentucky	0.99835
Louisiana	0.99835
Maine	0.99835

State	Rural floor budget neutrality adjustment factor
Maryland *	------
Massachusetts	0.99835
Michigan	0.99835
Minnesota	0.99835
Mississippi	0.99835
Missouri	0.99835
Montana	0.99835
Nebraska	0.99835
Nevada	0.99835
New Hampshire	0.99698
New Jersey **	0.98437
New Mexico	0.99576
New York	0.99836
North Carolina	0.99833
North Dakota	0.99668
Ohio	0.99783
Oklahoma	0.99835
Oregon	0.99705
Pennsylvania	0.99812
Puerto Rico	0.99835

Rural floor budget neutrality factors for acute care hospitals fiscal year 2010 – CR 6634 Attachment A (continued)

State	Rural floor budget neutrality adjustment factor
Rhode Island	0.99835
South Carolina	0.99778
South Dakota	0.99835
Tennessee	0.99691
Texas	0.99835
Utah	0.99835

State	Rural floor budget neutrality adjustment factor
Vermont	0.99835
Virginia	0.99835
Washington	0.99792
West Virginia	0.99714
Wisconsin	0.99816
Wyoming	0.99835

* Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS rate setting. Therefore, the rural floor budget neutrality adjustment does not apply.
** The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see Table 4B).

Section 505 adjustment: Provider numbers and corresponding special wage indexes

CR 6634 Attachment B

010008	0.7563
010015	0.7435
010021	0.7441
010027	0.7415
010032	0.7714
010038	0.7650
010040	0.8411
010045	0.7611
010046	0.8411
010047	0.7516
010049	0.7415
010078	0.7650
010091	0.7435
010109	0.7794
010110	0.7604
010125	0.7865
010128	0.7435
010129	0.7523
010138	0.7455
010146	0.7650
010150	0.7516
030067	0.9099
040047	0.7676
040067	0.7566
040081	0.7916
040149	0.7758
050007	1.5600
050070	1.5600

050090	1.5541
050113	1.5600
050118	1.2377
050122	1.2377
050136	1.5541
050167	1.2377
050174	1.5541
050289	1.5600
050291	1.5541
050298	1.1756
050313	1.2377
050325	1.1778
050336	1.2377
050366	1.1760
050385	1.5541
050444	1.2086
050547	1.5541
050690	1.5541
050748	1.2377
050754	1.5600
080001	1.0786
080003	1.0786
090001	1.0733
090003	1.0733
090005	1.0733
090006	1.0733
090008	1.0733
100290	0.8932

110100	0.8609
110101	0.7886
110142	0.8004
110190	0.8060
110205	0.8326
130024	0.8318
130066	0.9380
140001	0.8691
140026	0.8637
140116	1.0399
140176	1.0399
140234	0.8637
150022	0.8671
150072	0.8618
160013	0.8743
160030	0.9546
160032	0.8799
170150	0.8349
180064	0.8275
180070	0.8201
180079	0.8220
190034	0.8013
190044	0.8085
190050	0.7868
190053	0.7925
190054	0.7909
190078	0.8011
190099	0.8013

190116	0.7909
190133	0.7926
190140	0.7859
190145	0.7914
190246	0.7899
200032	0.8922
230005	0.9270
230015	0.9092
230041	0.9498
230047	0.9879
230075	1.0121
230093	0.8855
230099	1.0193
230204	0.9879
230217	1.0121
230227	0.9879
230257	0.9879
230264	0.9879
230301	0.9883
240018	1.0071
240044	0.9891
240117	0.9793
240211	1.0078
250128	0.8163
250162	0.8737
260059	0.8241
260097	0.8464
260160	0.8308

Section 505 adjustment: Provider numbers and corresponding special wage indexes – CR 6634 Attachment B (continued)

260163	0.8251
320011	0.9301
320018	0.8988
320085	0.8988
320088	0.8988
330010	0.8541
330033	0.8697
330047	0.8541
330103	0.8605
330106	1.2841
330132	0.8605
330135	1.1908
330144	0.8530
330151	0.8530
330175	0.8734
330205	1.1908
330264	1.1908
330276	0.8510
340020	0.8749
340024	0.8770
340037	0.8755
340038	0.8846
340068	0.8680
340070	0.9042
340104	0.8755
340133	0.8853
340151	0.8645
360002	0.8656
360040	0.8902
360044	0.8642
360070	0.8666
360071	0.8550
360084	0.8666
360096	0.8586
360107	0.8634

360131	0.8666
360151	0.8666
360156	0.8634
360161	0.8673
370023	0.7897
370065	0.7903
370072	0.8065
370083	0.7858
370100	0.7907
370156	0.7928
370169	0.7970
370172	1.4682
370214	0.7928
390008	0.8423
390039	0.8400
390052	0.8410
390056	0.8399
390112	0.8400
390117	0.8365
390122	0.8416
390125	0.8385
390146	0.8385
390150	0.8394
390173	0.8400
390201	0.9533
390236	0.8366
390316	0.9403
420002	0.9316
420019	0.8547
420043	0.8546
420053	0.8424
420054	0.8391
420082	0.9442
430008	0.8895
430048	0.8489

430094	0.8489
440007	0.8109
440008	0.8339
440012	0.8120
440016	0.8034
440017	0.8120
440031	0.7909
440033	0.7917
440047	0.8228
440050	0.7899
440051	0.7972
440057	0.7911
440060	0.8228
440063	0.7923
440070	0.7999
440081	0.7942
440084	0.7915
440105	0.7923
440109	0.7960
440115	0.8228
440137	0.8628
440176	0.8120
440180	0.7917
440181	0.8255
440182	0.8034
440184	0.7923
450052	0.7944
450059	0.8988
450090	0.8594
450163	0.7998
450192	0.8215
450194	0.8157
450210	0.8095
450236	0.8333
450270	0.8215

450395	0.8385
450451	0.8480
450460	0.7997
450497	0.8319
450539	0.8011
450573	0.8070
450615	0.7977
450641	0.8319
450698	0.8071
450755	0.8220
450813	0.8070
450838	0.8070
450884	0.8288
450888	0.9458
460001	0.9444
460013	0.9444
460017	0.8825
460023	0.9444
460043	0.9444
460052	0.9444
490002	0.8104
490038	0.8104
490084	0.8288
490105	0.8104
490110	0.8534
500019	1.0250
510012	0.7594
520035	0.9334
520044	0.9334
520045	0.9248
520048	0.9248
520057	0.9419
520198	0.9248

Hospital quality initiative
CR 6634 Attachment C

State	HSP ID	Hospital name
AL	010015	SOUTHWEST ALABAMA MEDICAL CENTER
AL	010052	LAKE MARTIN COMMUNITY HOSPITAL
AZ	030074	SELLS INDIAN HEALTH SERVICE HOSPITAL
AZ	030113	WHITERIVER PHS INDIAN HOSPITAL
CA	050091	COMMUNITY AND MISSION HOSPITAL OF HUNTINGTON PARK
CA	050110	LOMPOC VALLEY MEDICAL CENTER
CA	050193	SOUTH COAST MEDICAL CENTER
CA	050205	EAST VALLEY HOSPITAL MEDICAL CENTER
CA	050301	UKIAH VALLEY MEDICAL CENTER/HOSPITAL D
CA	050325	TUOLUMNE GENERAL MEDICAL FACILITY
CA	050342	PIONEERS MEMORIAL HEALTHCARE DISTRICT
CA	050378	PACIFICA HOSPITAL OF THE VALLEY
CA	050385	PALM DRIVE HOSPITAL
CA	050423	PALO VERDE HOSPITAL
CA	050433	INDIAN VALLEY HOSPITAL
CA	050545	LANTERMAN DEVELOPMENTAL CENTER
CA	050546	PORTERVILLE DEVELOPMENTAL CENTER
CA	050548	FAIRVIEW DEVELOPMENTAL CENTER
CA	050662	AGNEWS STATE HOSPITAL
CA	050667	N M HOLDERMAN MEMORIAL HOSPITAL
CA	050682	KINGSBURG MEDICAL CENTER
CA	050698	SAN DIEGO HOSPICE & THE INSTITUTE FOR PALLIATIVE MEDICINE
CA	050740	MARINA DEL REY HOSPITAL
CA	050751	MIRACLE MILE MEDICAL CENTER
CA	050760	KAISER FOUNDATION HOSPITAL – ANTIOCH
CO	060049	YAMPA VALLEY MEDICAL CENTER
CT	070038	CONNECTICUT HOSPICE INC.
FL	100105	INDIAN RIVER MEMORIAL HOSPITAL INC
FL	100134	ED FRASER MEMORIAL HOSPITAL
FL	100139	NATURE COAST REGIONAL HOSPITAL
FL	100298	FLORIDA STATE HOSPITAL UNIT 31 MED
HI	120004	WAHIAWA GENERAL HOSPITAL
ID	130062	IDAHO FALLS RECOVERY CENTER
IL	140033	VISTA MEDICAL CENTER WEST
IL	140082	VHS ACQUISTION DBA LOUIS A WEISS MEMORIAL HOSPITAL
IL	140151	SACRED HEART HOSPITAL
IL	140205	SWEDISH AMERICAN MEDICAL CENTER BELVIDERE
IN	150166	PINNACLE HOSPITAL
KS	170180	MEADOWBROOK REHABILITATION HOSPITAL
LA	190037	SOUTH CAMERON MEMORIAL HOSPITAL

Hospital quality initiative – CR 6634 Attachment C (continued)

State	HSP ID	Hospital name
LA	190118	DESOTO REGIONAL HEALTH SYSTEM
LA	190161	W O MOSS REGIONAL MEDICAL CENTER
LA	190208	EAST CARROLL PARISH HOSPITAL
LA	190245	MONROE SURGICAL HOSPITAL
[LA]	[190258]	[BOSSIER SPECIALTY HOSPITAL]
LA	190297	DOCTORS HOSPITAL AT DEER CREEK LLC
MA	220153	SOLDIERS HOME OF HOLYOKE
MA	220154	CHELSEA SOLDIERS HOME
MA	220172	UNIVERSITY HEALTH SERVICES
MA	220177	NANTUCKET COTTAGE HOSPITAL
MI	230135	HENRY FORD COTTAGE HOSPITAL
MI	230144	FOREST HEALTH MEDICAL CENTER
MN	240196	PHILLIPS EYE INSTITUTE
MS	250018	JASPER GENERAL HOSPITAL
MS	250060	JEFFERSON COUNTY HOSPITAL
MS	250079	SHARKEY ISSAQUENA COMMUNITY HOSPITAL
MS	250127	CHOCTAW HEALTH CENTER
MS	250149	NEWTON REGIONAL HOSPITAL
MS	250151	ALLIANCE HEALTH CENTER
MS	250152	MISSISSIPPI METHODIST REHAB CTR
MO	260104	SSM DEPAUL HEALTH CENTER
NE	280119	P H S INDIAN HOSPITAL
NV	290002	SOUTH LYON MEDICAL CENTER
NV	290020	NYE REGIONAL MEDICAL CENTER
NV	290027	GROVER C DILS MEDICAL CENTER
NV	290042	HARMON MEDICAL AND REHABILITATION HOSPITAL
NM	320057	SANTA FE PHS INDIAN HOSPITAL
NY	330010	AMSTERDAM MEMORIAL HEALTH CARE SYSTEM
NY	330407	EDDY COHOES REHABILITATION CENTER
NY	330408	TRI-TOWN REGIONAL HEALTHCARE
NC	340104	CRAWLEY MEMORIAL HOSPITAL
NC	340138	CENTRAL REGIONAL HOSPITAL
NC	340168	WILMINGTON TREATMENT CENTER
OH	360046	MCCULLOUGH-HYDE MEMORIAL HOSPITAL
OH	360241	EDWIN SHAW REHAB, LLC
OH	360247	WOODS AT PARKSIDE,THE
OH	360258	BARIX CLINICS OF OHIO, LLC
OH	360349	ADVANCED SPECIALTY HOSPITAL OF TOLEDO
OK	370011	PARKVIEW HOSPITAL
OK	370214	LINDSAY MUNICIPAL HOSPITAL
OK	370220	ORTHOPEDIC HOSPITAL

Hospital quality initiative – CR 6634 Attachment C (continued)

State	HSP ID	Hospital name
PA	390104	KANE COMMUNITY HOSPITAL
PA	390302	BARIX CLINICS OF PENNSYLVANIA
SD	430060	HOLY INFANT HOSPITAL
SD	430081	PINE RIDGE IHS HOSPITAL
SD	430083	PHS INDIAN HOSPITAL AT EAGLE BUTTE
SD	430084	ROSEBUD IHS HOSPITAL
SD	430093	SAME DAY SURGERY CENTER LLC
SD	430096	LEWIS AND CLARK SPECIALTY HOSPITAL
TN	440007	UNITED REGIONAL MEDICAL CENTER
TN	440026	ROLLING HILLS NASHVILLE REHAB HOSPITAL
TN	440147	BAPTIST REHABILITATION GERMANTOWN
TN	440162	HEALTHSOUTH CHATTANOOGA REHAB HOSPITAL
TN	440181	BOLIVAR GENERAL HOSPITAL
TN	440218	THE CENTER FOR SPINAL SURGERY
TX	450044	U.T. SOUTHWESTERN UNIVERSITY HOSPITAL - ST. PAUL
TX	450253	BELLVILLE GENERAL HOSPITAL
TX	450283	COZBY-GERMANY HOSPITAL
TX	450446	RIVERSIDE GENERAL HOSPITAL
TX	450460	TYLER COUNTY HOSPITAL
TX	450683	RENAISSANCE HOSPITAL TERRELL
TX	450749	EAST TEXAS MEDICAL CENTER TRINITY
TX	450766	U.T. SOUTHWESTERN UNIVERSITY HOSPITAL – ZALE LIPSHY
TX	450770	CENTRAL TEXAS HOSPITAL
TX	450796	NORTHWEST TEXAS SURGERY CENTER
TX	450813	COMMUNITY GENERAL HOSPITAL
TX	450831	SURGERY SPECIALTY HOSPITALS OF AMERICA
TX	450839	SHELBY REGIONAL MEDICAL CENTER
TX	450845	EL PASO SPECIALTY HOSPITAL
UT	460018	KANE COUNTY HOSPITAL
UT	460035	BEAVER VALLEY HOSPITAL
VA	490002	RUSSELL COUNTY MEDICAL CENTER
VA	490104	HIRAM W DAVIS MEDICAL CENTER
VA	490105	SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
VA	490108	CENTRAL VIRGINIA TRAINING CENTER
VA	490129	CAPITAL HOSPICE - HALQUIST MEMORIAL INPATIENT CENTER
VA	490134	PIEDMONT GERIATRIC HOSPITAL
VA	490135	CATAWBA HOSPITAL
WY	530017	SOUTH LINCOLN MEDICAL CENTER
TX	670007	BEAUMONT BONE & JOINT INSTITUTE
TX	670008	HOUSTON PHYSICIANS' HOSPITAL
TX	670010	DENTON REHABILITATION HOSPITAL L.P.

Hospital quality initiative – CR 6634 Attachment C (continued)

State	HSP ID	Hospital name
TX	670021	INNOVA HOSPITAL SAN ANTONIO
TX	670027	ACUITY HOSPITAL OF HOUSTON
TX	670029	FIRST STREET HOSPITAL LP
TX	670040	ATRIUM MEDICAL CENTER
TX	670045	COOK CHILDRENS NORTHEAST HOSPITAL, L.L.C.
TX	670050	TRUSTPOINT HOSPITAL

Wage-index changes

CR 6634 Attachment D

Wage-index values have changed for the following areas per the FY 2010 correction notice.

Note: These wage index values do not have the state specific blended rural floor budget neutrality factors applied. The state specific rural floor budget neutrality factors are published in Attachment A for this CR.

Area reclass				
Record	**CBSA**	**WIX**	**WIX**	**CBSA Name**
New	05	**1.1901**	**1.1901**	CALIFORNIA
Old	05	**1.1814**	**1.1814**	CALIFORNIA
New	10900	1.1521	**0.9829**	Allentown-Bethlehem-Easton, PA-NJ
Old	10900	1.1521	**0.9654**	Allentown-Bethlehem-Easton, PA-NJ
New	12540	**1.1901**	0	Bakersfield, CA
Old	12540	**1.1814**	0	Bakersfield, CA
New	15380	**0.9825**	**0.9825**	Buffalo-Niagara Falls, NY
Old	15380	**0.9816**	**0.9816**	Buffalo-Niagara Falls, NY
New	17020	**1.1901**	0	Chico, CA
Old	17020	**1.1814**	0	Chico, CA
New	19804	**0.9793**	**0**	Detroit-Livonia-Dearborn, MI
Old	19804	**0.9804**	**0.9804**	Detroit-Livonia-Dearborn, MI
New	20940	**1.1901**	0	El Centro, CA
Old	20940	**1.1814**	0	El Centro, CA
New	23420	**1.1901**	0	Fresno, CA
Old	23420	**1.1814**	0	Fresno, CA
New	23844	**0.9185**	**0.9185**	Gary, IN
Old	23844	**0.9213**	**0.9213**	Gary, IN
New	25260	**1.1901**	0	Hanford-Corcoran, CA
Old	25260	**1.1814**	0	Hanford-Corcoran, CA
New	31084	1.196	**1.1901**	Los Angeles-Long Beach-Santa Ana, CA
Old	31084	1.196	**1.1835**	Los Angeles-Long Beach-Santa Ana, CA

Wage-index changes – CR 6634 Attachment D (continued)

Area reclass				
Record	**CBSA**	**WIX**	**WIX**	**CBSA Name**
New	31460	**1.1901**	0	Madera-Chowchilla, CA
Old	31460	**1.1814**	0	Madera-Chowchilla, CA
New	33700	1.241	**1.2274**	Modesto, CA
Old	33700	1.241	**1.241**	Modesto, CA
New	40140	**1.1901**	1.1165	Riverside-San Bernardino-Ontario, CA
Old	40140	**1.1814**	1.1165	Riverside-San Bernardino-Ontario, CA
New	1740	**1.1901**	0	San Diego-Carlsbad-San Marcos, CA
Old	41740	**1.1814**	0	San Diego-Carlsbad-San Marcos, CA
New	42044	**1.1901**	**1.1901**	Santa Ana-Anaheim-Irvine, CA
Old	42044	**1.1814**	**1.1814**	Santa Ana-Anaheim-Irvine, CA
New	47300	**1.1901**	0	Visalia-Porteville, CA
Old	47300	**1.1814**	0	Visalia-Porteville, CA
New	49700	**1.1901**	0	Yuba City, CA
Old	49700	**1.1814**	0	Yuba City, CA

Wrong surgical/other invasive procedure performed on a patient and/or body part

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 MM6405 to reflect the issuance of a revised change request (CR) 6405. As a result, the CR release date, transmittal number, and the Web address for accessing CR 6405 were changed. Also, for the revisions to the *Medicare Claims Processing Manual*, see the article related to CR 6634 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6634.pdf*. All other information remains the same. The *MLN Matters* article MM6405 was published in the July 2009 *Medicare A Bulletin* (pages 21-23).

Provider types affected

Physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs] or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, sections 10 and [120] and Chapter 16, Section [180]. This is pursuant to the national coverage determinations (NCDs) made as part of CR 6405.

Caution – what you need to know

For inpatient claims, hospitals are required to bill two claims when the erroneous surgery related to the NCD is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the noncovered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

Go – what you need to do

Make sure that your billing staff are aware of these new billing and claim requirements.

Background

In 2002, the National Quality Forum (NQF) published "Serious Reportable Events in Healthcare: A Consensus Report," which listed 27 adverse events that were "serious, largely preventable and of concern to both the public and health care providers." (That report is available on the Internet at *http://www.qualityforum.org/pdf/reports/sre.pdf*.)

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

These events and subsequent revisions to the list became known as "never events." This concept and need for the proposed reporting led to NQF's "Consensus Standards Maintenance Committee on Serious Reportable Events," which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally non cover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

1) a different procedure altogether;
2) the correct procedure but on the wrong body part; or
3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, Sections 10 and [120], and Chapter 16, Section [180]. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

Note: Related services do not include performance of the correct procedure.

Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the *Current Procedural Terminology (CPT)* and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.
- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

  Note: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).
- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

Beneficiary liability

Generally, a beneficiary liability notice such as an advance beneficiary notice of noncoverage (ABN) or a hospital issued notice of noncoverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the *Medicare Claims Processing Manual*, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the noncovered item/service. (The *Medicare Claims Processing Manual* is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the *Medicare Claims Processing Manual*, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the noncovered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the *Medicare Claims Processing Manual*.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the noncovered surgical error that would not be considered a related service to the noncovered surgical error (see Chapter 1, Sections 10 and [120], and Chapter 16, Section [180], of the *Benefit Policy Manual*).

Implementation

Inpatient claims

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the NCD is reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11x (with the exception of 110), and,

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

- The other claim with the noncovered service(s)/ procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
- Both the covered and noncovered claim must have a matching "Statement Covers Period."

The noncovered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in form locator (FL) 80 (Remarks), or the 837I (electronic) claim form, loop 2300, one of the applicable two-digit surgical error codes as follows:

- MX – for a wrong surgery on patient;
- MY – for surgery on the wrong body part; or
- MZ – for surgery on the wrong patient.

For discharges on or after October 1, 2009, hospitals will refer to *MLN Matters*® article MM6634 for how to submit an erroneous surgery claim. MM6634 may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6634.pdf*.

The claim for the noncovered services will be denied using:

- **Claim adjustment reason code (CARC) 50** – these are noncovered services because this is not deemed a 'medical necessity' by the payer.
- **Group code CO** – contractual obligation.

Outpatient, ambulatory surgical centers (ASCs), other appropriate bill types and practitioner claims

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery wrong body part
- PB: Surgery wrong patient
- PC: Wrong surgery on patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system control facility (SCF) rule shall be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- **CARC 50** – These are noncovered services because this is not deemed a "medical necessity" by the payer.
- **Group code – CO** – contractual obligation

Related claims

Within **five** days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

Additional information

For complete details regarding this change request (CR) please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the national coverage determination related to this issue and that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf*.

The other transmittal presents the Medicare Claims Processing Manual revision and instructions. That transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1819CP.pdf*.

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

MLN Matters® Number: MM6405 – Revised
Related Change Request (CR) Number: 6405
Related CR Release Date: September 25, 2009
Related CR Transmittal Number: R1819CP and R102NCD
Effective Date: January 15, 2009
Implementation Date: July 6, 2009, for those billing carriers and Part B MACs; October 5, 2009, for FIs and Part A MACs

Source: CMS Pub. 100-04, Transmittal 1819, CR 6405

ESRD Services

Fistula first breakthrough initiative provides roadmap to reach 66 percent goal

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the Fistula First Breakthrough Initiative (FFBI) has released a strategic plan that aims to achieve CMS goal that two-thirds (66 percent) of prevalent hemodialysis patients will use an arteriovenous (AV) fistula as their primary method of vascular access.

The FFBI strategic plan focuses on seven strategies and two policy recommendations. The plan was developed by conducting a root-cause analysis that identified the underlying barriers to AV fistula placement and use. A technical expert panel identified potential solutions to address the root causes.

Led by the FFBI coalition, with support from the end-stage renal disease (ESRD) network organizations and the quality improvement organizations (QIOs) under CMS leadership, the strategic plan includes the following concepts:

1. **Nephrologist as leader:** Encourage and support nephrologists to take a leadership role and be accountable for vascular access management in all hemodialysis patients.
2. **Leveraging partnerships:** Partner with organizations to improve AV fistula placement and utilization rates.
3. **Hospital systems:** Modify hospital systems to promote AV fistula placement.
4. **Patient self-management:** Promote patient self-management through the stages of chronic kidney disease.
5. **Addressing access problems:** Promote fast-track protocols for rapid identification and referral of vascular access problems, which include failure to mature, revisions of the failing AV fistula, and failure to place an AV fistula.
6. **Practitioner training and credentialing:** Promote training, experience, and credentialing of healthcare professionals in the area of hemodialysis vascular access management.
7. **FFBI change concepts:** Expand and endorse the current change concepts for education and promotion throughout the renal, surgical, and interventional communities.

The percentage of prevalent hemodialysis patients in the U.S. with an AV fistula as their primary vascular access was 32.4 percent (87,344 patients) at the beginning of 2003. By May 2009, this percentage had increased to 52.6 percent (179,113 patients). As a result, nearly 92,000 additional patients experienced improved adequacy, fewer hospitalizations, fewer infections, and a lowered mortality risk than those with other forms of vascular access. The dramatic change in practice patterns that produced the improvement was due to the targeted efforts of many organizations and individuals, facilitated by the Fistula First Breakthrough Initiative. However, the CMS goal, based upon achievable practice, is a prevalent AV fistula utilization rate of 66 percent, which means that there are additional opportunities for improvement.

The FFBI strategic plan presents recommendations for accountability and organizational, behavioral, and infrastructural changes across health care systems which, if implemented, will result in sustainable outcomes improvement.

To read the FFBI strategic plan online, please visit on the Internet *http://www.fistulafirst.org*.

To learn more about the portfolio of CMS ESRD quality projects online, visit the CMS Web site *http://www.cms.hhs.gov/ESRDQualityImproveInit/*. ❖

Source: CMS PERL 200910-23

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

SKILLED NURSING FACILITY SERVICES

Reminder about correct billing changes for certain skilled nursing facility residents

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

Provider types affected

Skilled nursing facilities (SNFs) and hospital swing beds to Medicare contractors (fiscal intermediaries (FIs) or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed stop – impact to you

This special edition article is being provided because the Centers for Medicare & Medicaid Services (CMS) has identified an issue related to the planned implementation of new case mix index (CMI) sets for fiscal year (FY) 2010 announced in the *Federal Register* on August 11, 2009.

Caution – what you need to know

Beneficiaries may often qualify for more than one RUG (resource utilization group) group. For payment, the record is assigned to the RUG group that pays the greatest amount; i.e., the RUG classification is index maximized. For a short period of time during the transition to fiscal year 2010, the payment rates will be calculated incorrectly for a limited number of residents in rural facilities. For rural facilities, the index maximization changes from FY 2009 to FY 2010 for the classification of residents who qualify for both the RVL (Very high rehabilitation plus extensive services) and RMX (medium rehabilitation plus extensive services) RUGs and have an activity of daily living (ADL) score of exactly 15. For FY 2009, these residents index maximize at RMX, however for FY 2010, these residents should now index maximize at RVL. The new CMI sets effective for FY 2010 will allow assessment reference dates on or after October 1, 2009, to reclassify residents to the correct RVL group. However, in situations where the assessment will be used to determine the RUG group for days of service both before and after October 1, 2009, incorrect payment will occur for part of this timeframe. In these instances, the GROUPER will only provide one RUG; however, since the days of service span October 1, payment should be made for two separate rates.

Go – what you need to do

Providers should make a manual correction to bill the Medicare days at the correct RVL rate, and document the change on either the appropriate validation report or in the medical record. Please note that CMS expects this situation to occur very rarely.

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

Background

Skilled nursing facilities (SNFs) are paid based on case-mix classification groups called resource utilization groups version III (RUG-III). Medicare uses a case-mix classification system to assign a nursing home resident to a RUG category based on his or her medical conditions and the resources needed to provide care. Each RUG category is tied to a Medicare payment rate. Medicare RUG classifications use the 'index-maximization' method, and under the 'index-maximization' method, if a resident qualifies for more than one RUG group, the resident will be placed in the group with the highest case-mix index (CMI), i.e., with the highest payment rate.

CMS announced in the *Federal Register* on August 11, 2009, that, effective October 1, 2009, adjustments will be made to the SNF payment rates for FY 2010. You may review the final rule on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-18662.pdf*.

This special edition article is being provided because CMS has identified an issue related to the planned implementation of new CMI sets for fiscal year 2010. For FY 2010, the payment rate ordering will change for a limited number of residents in rural facilities.

Note: If providers fail to implement the special billing instructions below for the affected residents, they risk being paid less than the qualifying amount for services during the transition time.

For rural facilities, the index maximization changes the classification for a small number of residents who qualify for both the RVL (Very High Rehabilitation Plus Extensive Services) and RMX (Medium Rehabilitation Plus Extensive Services) RUG-III groups and have an activity of daily living (ADL) score of exactly 15.

- For FY 2009, these residents index maximized at RMX; and
- For FY 2010, these residents should now index maximize at RVL.

Index maximization is determined by using the RUG-III GROUPER in conjunction with the appropriate CMI sets, and new CMI sets will be available on the minimum data set case mix index (MDS CMI) on the CMS Web site at *http://www.cms.hhs.gov/MDS20SWSpecs/09_RUG-IIIVersion5.asp#TopOfPage*.

Information related to hospital swing beds will be available on the CMS Web site at *http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp#TopOfPage*.

The new CMI sets are effective for FY 2010 and will allow assessment reference dates on or after October 1, 2009, to reclassify residents to the correct RVL group.

Reminder about correct billing changes for certain skilled nursing facility residents (continued)

However, this becomes an issue for a very small number of residents where the days of service cross October 1, 2009. In these instances, the grouper will only provide one RUG-III group, however since the days of service span October 1, payment should be made for two separate rates.

There are two scenarios to consider:

1. **PPS assessments with a reference date before October 1, 2009, applied to days of service on or after October 1, 2009.**
   In these instances, the GROUPER will classify the resident as RMX, however for days of service on or after October 1, 2009, they should classify as RVL.
   The MDS state system calculated RUG-III classification using the FY 2009 CMI set will be correct for use on or after October 1, 2009, except for some assessments with an RMX classification. Assessments that are problematic meet all of the following conditions:
   - The assessment reference date (MDS Item A3a) is before October 1, 2009
   - The assessment is used to bill days of service on or after October 1, 2009
   - The obtained classification using the FY 2009 CMI set is RMX
   - The ADL score for the assessment is exactly 15
   - 500 or more minutes of rehabilitation therapy are received across all three therapies (speech, occupational, and physical therapy)

     That is: P1baB + P1bbB + P1bcB >= 500
   - One of the three rehabilitation therapies is received for 5 or more days.
     That is: P1baA >= 5 OR P1bbA >= 5 OR P1bcA >= 5

     If all of these conditions are satisfied, then the RUG-III classification for days of service on or after October 1, 2009, is RVL rather than RMX. In this situation, SNFs should bill a RUG code of RMX for days of service prior to October 1, 2009, and RVL for days of service on or after October 1, 2009.

2. **PPS assessments with reference date on or after October 1, 2009, applied to days of service before October 1, 2009.**
   In these instances, the grouper will classify the resident as RVL, however for days of service prior to October 1, 2009 they should classify as RMX.
   The MDS state system calculated RUG-III classification using the FY 2010 CMI set will be correct for use before October 1, 2009, except for some assessments with an RVL classification. Assessments that are problematic meet all of the following conditions:
   - The assessment reference date (MDS Item A3a) is on or after October 1, 2009
   - The assessment is used to bill days of service before October 1, 2009
   - The obtained classification using the FY 2010 CMI set is RVL
   - The ADL score for the assessment is exactly 15.

     If all these conditions are met, then the RUG-III classification for days of service before October 1, 2009, is RMX rather than RVL. In these instances, SNFs should bill the RUG code of RMX for days of service prior to October 1, 2009, and RVL for days of service on or after October 1, 2009.

Additional information

For a one-stop resource Web page focused on the informational needs and interests of Medicare fee-for-service (FFS) SNFs, go to the SNF Center on the CMS Web site at *http://www.cms.hhs.gov/center/snf.asp*.

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

MLN Matters® Number: SE0923
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 SE0923

Enrollment Application Reminder

Providers submitting a Medicare enrollment application CMS-855A, CMS-855B or CMS-855I must submit the **nine-digit ZIP** code for each practice location listed on the form.

Five-star quality rating system

October news

1. The five-star provider preview reports will be available beginning Monday, October 12, 2009. Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of minimum data set data.

Provider preview access information

- Visit the MDS state welcome page available on the state servers where you submit MDS data to review your results.
- To access these reports, select the certification and survey provider enhanced reports (CASPER) reporting link located at the bottom of the login page.
- Once in the CASPER reporting system:

  i. Click on the ”folders” button and access the five-star report in your “st LTC facid” folder

  ii. Where st is the two-digit postal code of the state in which your facility is located

  iii. Facid is the state assigned facid of your facility.

2. The helpline will be open beginning Monday, October 12, 2009, for questions and concerns about the July data. Alternatively, providers can write to *BetterCare@cms.hhs.gov*.
3. Nursing Home Compare was updated on Thursday, October 22, 2009, with the five-star data from October.
4. For the latest five-star quality rating system, please visit *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp*. ❖

Source: CMS PERL 200910-11

Keep Informed

Join *e-News*, FCSO e-mailing list to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and find ways to improve Medicare billing and payment efficiency.

CORF/ORF SERVICES

Comprehensive outpatient rehabilitation facility coverage

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

Provider types affected

Comprehensive outpatient rehabilitation facilities who bill Medicare fiscal intermediaries (FI) and Medicare administrative contractors (A/B MAC) for providing comprehensive outpatient rehabilitation facility (CORF) services to Medicare beneficiaries.

What you need to know

Change request (CR) 6005, from which this article is taken, announces that, based on changes in the 2008 Medicare physician fee schedule (MPFS) regulation (Published in the *Federal Register* on November 27, 2007), the *Medicare Benefit Policy Manual*, Chapter 12, (Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage) has been amended to clarify general requirements, covered and noncovered services, provisions of services, and particular CORF services

Specifically (effective January 1, 2008), these changes are incorporated in the manual: 1) define that all CORF services must be directly related to the physical therapy (PT), occupational therapy (OT), speech language pathology (SLP) or respiratory therapy (RT) rehabilitation therapy plan of treatment; and 2) clarify that the physician must wholly develop the rehabilitation therapy plan of treatment, 3) only a respiratory therapist (not a respiratory technician) can provide respiratory therapy, 4) social and psychological services (not mental health services) are core CORF services (which must be reasonable and medically necessary and directly related to the PT, OPT, SLP, or RT rehabilitation therapy plan of treatment), and 5) that physician "incident-to" services cannot be provided in a CORF.

Make sure that your billing staffs are aware of these CORF manual changes.

Background

CR 6005 announces that (effective January 1, 2008) the *Medicare Benefit Policy Manual*, Chapter 12 (Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage) is amended to reflect changes announced in the 2008 MPFS regulation and to clarify general requirements, covered and noncovered services, provisions of services, and specific CORF services.

Note: A CORF's purpose is to permit the beneficiary to receive multidisciplinary rehabilitation services at a single location in a coordinated fashion. Section 1861 (cc) of the Social Security Act specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service when provided to a hospital patient. (This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care), but rather only that the service would be covered if provided in a hospital. The requirement for CORF outpatient mental health limitation is deleted.

The policy changes that CR 6005 announces are synthesized below.

- CORF services are covered **only** if they are medically necessary and relate directly to the rehabilitation of injured, disabled, or sick patients.

Required services

The CORF must provide these core services: a) CORF physicians' services, b) physical therapy services, and c) social and psychological services.

1. CORF physician services are those physician-performed professional services that are administrative in nature; such as consultation with, and medical supervision of, non-physician staff; patient case review conferences; utilization review; the review of the therapy/pathology plan of treatment, as appropriate; and other facility medical and administration activities necessary to provide skilled rehabilitation services (those that PTs, OTs, SLPs and RTs provide), and other services that directly relate to the rehabilitation plan of treatment.
   Please be aware that diagnostic or therapeutic services that a CORF (or other) physician provides to a CORF patient are not CORF physician services. These services are separately payable to the physician under the MPFS, at the non-facility payment amount billed as if provided in the physician's office.
   Remember that to become a CORF patient, a beneficiary must be under the care of a physician who certifies that he/she needs skilled rehabilitation services. If the referring physician does not specify the rehabilitation goals for PT, OT, SLP, or RT services; the CORF physician must established them. Further, either the referring physician or the CORF physician must establish, and sign, a rehabilitation plan of treatment prior to the beginning treatment.
   In addition, the CORF physician or the referring physician, must review the treatment plan for respiratory therapy services at least every 60 days; and for physical therapy, occupational therapy, speech-language pathology, and for all other services at least once every 90 days; certifying that the plan is being followed and that the patient is making progress in attaining the established rehabilitation goals.

   Note: The CORF physician must be present in the facility enough to ensure that CORF services are provided in accordance with accepted principles of medical practice, medical direction, and medical supervision.

2. Physical therapy services should comprise a clear majority of the total CORF services. To supervise CORF physical therapy services, the physical therapist

Comprehensive outpatient rehabilitation facility coverage (continued)

must be on the CORF premises (or must be available to the physical therapy assistant through direct telecommunications for consultation and assistance) during the CORF's operating hours.

3. Social and psychological services are covered only if the patient's physician (or CORF physician) establishes that the services directly relate to the patients rehabilitation plan of treatment and are needed to obtain the rehabilitation goals. Social and psychological services include only those services that address the patient's response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation goals; or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory plan of treatment.

   Notes: 1) CORF social and psychological services are the same, whether provided by either a qualified social worker or psychologist. Qualifications for individuals providing CORF social and psychological services are a Bachelors of Science for social workers and a Masters-level degree for psychologist; 2) Social and psychological services do not include services for mental health diagnoses.

Optional services

In addition to the above three required core services, the CORF may also furnish the following other covered and medically necessary items and services; as long as they directly relate to, and are consistent with, the rehabilitation treatment plan, and are necessary to achieve the rehabilitation goals.

1. Occupational therapy services
2. Speech-language pathology services
3. Respiratory therapy services include only those services that a qualified respiratory therapist can appropriately provide to CORF patients under a physician-established respiratory therapy plan of treatment, in accordance with current medical and clinical standards.

   These services include the physiological monitoring necessary to furnish them, and rather than paid separately, the payment is bundled into the payment for respiratory therapy services. Diagnostic and other medical services provided in the CORF setting are not considered CORF services, and therefore may not be included in a respiratory therapy plan of treatment because these are covered under separate benefit categories.
   Please take note that services performed by respiratory therapy technicians are not covered because the current medical standards for skilled respiratory therapy services provided to patients in the CORF setting require the educational requirements of respiratory therapists.

   Examples of specific RT CORF services include the respiratory therapist assessing the patient to determine the appropriateness of pursed lip breathing activity and checking the patient's oxygen saturation level (via pulse oximetry). If appropriate, the respiratory therapist may then provide the initial training in order to ensure that the patient can accurately perform this activity; and again check the patient's oxygen saturation level, or perform peak respiratory flow, or other respiratory parameters.
   These types of services are considered "physiological monitoring" and are bundled into the payment for Healthcare Common Procedure Coding System (HCPCS) codes G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes [includes monitoring]), G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes [includes monitoring]), and G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals [includes monitoring]).
   Another example of monitoring includes the provision of a six-minute walk test that is typically conducted before the start of the patient's respiratory therapy activities, and the time to provide this walk "test" assessment can be included as part of the HCPCS code G0238.

   Note: Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist.

4. Prosthetic and orthotic devices are covered, including the testing, fitting, or training in their use
5. Nursing services (which must be provided by an individual meeting the qualifications of a registered nurse [RN], rather than a licensed practical nurse [LPN]) are provided as an adjunct to the rehabilitation treatment plan of treatment, and must be reasonable and medically necessary. For example, a registered nurse may perform (including patient instruction): the proper procedure of "in and out" urethral catheterization, tracheostomy tube suctioning, or the cleaning for ileostomy or colostomy bags.

   Note: Nursing services may not be a substitute for or supplant the services of physical therapists, occupational therapists, speech-language pathologist and respiratory therapists, but instead must lend support to or further the rehabilitation services and goals.

Comprehensive outpatient rehabilitation facility coverage (continued)

6. CORFs can provide pneumococcal, influenza, and hepatitis B vaccines to its patients provided the facility is "primarily engaged in providing (by or under the supervision of a physician) restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons."

   Note: Because no drugs and biologicals are currently identified as appropriate to a therapy rehabilitation treatment plan, CORFs may not submit claims for drugs and biologicals.

7. Supplies and durable medical rquipment (DME) – CORFs may not bill for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding *Current Procedural Terminology* code in the 29xxx series

8. Physical therapy, occupational therapy, and speech-language pathology services may be furnished in the patient's home, as CORF services, when payment for these therapy services is not otherwise made under the Medicare home health benefit, and

9. A single home PT, OT, or SLP environment evaluation visit, which includes evaluating the potential impact of the home environment on the rehabilitation goals, is limited to the services that one professional (who must be either a PT, OT, or SLP, as appropriate) provides, when the corresponding treatment plan identifies the home environment evaluation as necessary. The patient must be present during the home environment evaluation visit.

   Note: When, in addition to the required physical therapy, a CORF provides OT, SLP and/or RT services; the physical therapy services must represent the predominate rehabilitation service.

   Note: Hyperbaric oxygen services, infusion therapy services, cardiac rehabilitation services, or diagnostic sleep studies are not considered CORF services because they do not meet the definition, nor do they relate to the rehabilitation treatment plan. These, and other services not specifically listed as CORF services, may be covered under other Medicare benefits categories, such as physician services and diagnostic services.

Payment rules

The payment basis for CORF services is 80 percent of the lesser of: 1) the actual charge for the services; or 2) the MPFS amount for the service, when the MPFS establishes a payment amount for such service. Payment for CORF services under the PFS is made for all CORF services (PT, OT, SLP, RT, and the related nursing and social and psychological services); which are part of, or relate directly to, the rehabilitation treatment plan.

If there is no fee schedule amount for a covered CORF item or service, payment is based on the lesser of 80 percent of actual charges for the services provided or the amount determined by the local Medicare contractor.

Payment for covered DME, orthotic and prosthetic devices and supplies that a CORF provides is based on the lesser of 80 percent of actual charges; or the payment amount established under the DMEPOS fee schedule, or the single payment amount established under the DMEPOS competitive bidding program (provided that payment for such an item is not included in the payment amount for other CORF services).

Payment for CORF social and psychological services is made under the MPFS only for HCPCS Code G0409, as appropriate, only when billed using revenue codes 0560, 0569, 0910, 0911, 0914 and 0919.

Payment for CORF respiratory therapy services is made under the MPFS when provided by a respiratory therapist as defined at 42 CFR 485.70(j), only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment, and only when billed using revenue codes 0410, 0412 and 0419. When provided as part of a CORF respiratory therapy rehabilitation treatment plan, separate payment is not made for diagnostic tests or for services related to physiologic monitoring services; which are bundled into other therapy services appropriately performed by respiratory therapist, such as HCPCS G-codes G0237, G0238, and G0239. These three HCPCS codes are specific to services provided under the respiratory therapy plan of treatment and, as such, are not designated as subject to the therapy caps.

CORF nursing services are paid under the MPFS for nursing services, but only when provided by a registered nurse, and only to the extent that these services support or are an adjunct to the rehabilitation services that PTs, OTs, SLPs, and RTs provide, and are consistent with the rehabilitation treatment plan. In addition, payment for CORF nursing services is made only when provided by a registered nurse, and coded with HCPCS code G0128 (Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each per 10 minutes beyond the first 5 minutes) is used to bill for these services, and only with revenue codes revenue 0550 and 0559.

Note: Services provided under the "incident to" benefit may not be recognized as CORF services. Services furnished by CORF personnel, including registered nurses, physical therapists, occupational therapists, speech-language pathologist and respiratory therapists are not considered furnished incident-to physician services.

Payment for covered pneumococcal, influenza, and hepatitis B vaccines provided in the CORF setting is based on 95 percent of the average wholesale price. The registered nurse provides administration of the vaccines using *CPT* code *90471*.

Finally, CR 6005 announces that the requirement for CORF outpatient mental health treatment limitation is deleted.

Comprehensive outpatient rehabilitation facility coverage (continued)

Additional information

This article only summarizes the CORF manual revision made by CR 6005 and you may find the complete details by reviewing CR 6005, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R111BP.pdf*.

You will find the updated *Medicare Benefit Policy Manual*, Chapter 12, (Comprehensive Outpatient Rehabilitation Facility [CORF] Coverage), as an attachment to CR 6005.

In addition, for specific payment requirements for CORF, items and services, see the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), which you may find on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf*.

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

MLN Matters® Number: MM6005
Related Change Request (CR) Number: 6005
Related CR Release Date: September 25, 2009
Related CR Transmittal Number: R111BP
Effective Date: July 7, 2008
Implementation Date: October 26, 2009

Source: CMS Pub. 100-02, Transmittal 111, CR 6005

Timely claim ling guidelines

All Medicare claims must be submitted to the contractor within the established timeliness parameters. The time parameters are:

Dates of Service	Last Filing Date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011

ELECTRONIC DATA INTERCHANGE

Update of remittance advice remark codes and claim adjustment reason codes

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

Provider types affected

This article is for 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) 6604, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). Be sure billing staff are aware of these changes.

Background

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

Both code lists are posted on the Internet at *http://www.wpc-edi.com/Codes*.

The lists following the end of the *Additional Information* section summarizes the latest changes.

Additional information

To see the official instruction (CR 6604) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1804CP.pdf* on the CMS Web site.

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 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*.

New codes – CARC

Code	Current Narrative	Effective Date (per WPC posting)
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Health care Policy Identification Segment, if present.	1/1/2010

Modified codes – CARC

Code	Current Narrative	Effective Date (per WPC posting)
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 04/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010
50	These are noncovered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current Narrative	Effective Date (per WPC posting)
54	Multiple physicians/assistants are not covered in this case. This change to be effective 04/01/2010: Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010
55	Procedure/treatment is deemed experimental/investigational by the payer. This change to be effective 04/01/2010: Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. This change to be effective 04/01/2010: Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. This change to be effective 04/01/2010: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 04/01/2010: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Health care Policy Identification Segment, if present.	4/1/2010
90	Ingredient cost adjustment. This change to be effective 04/01/2010: Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	4/1/2010

Deactivated codes – CARC

Code	Current Narrative	Effective Date
156 *	Flexible spending account payments. Note: Use code 187.	10/1/2009

* Also included in CR 6453

New codes – RARC

Code	Current Narrative	Medicare Initiated
N519	Invalid combination of HCPCS modifiers.	No
N520	Alert: Payment made from a Consumer Spending Account.	No

Modified codes – RARC:

None

Deactivated codes – RARC

None

MLN Matters® Number: MM6604
Related Change Request (CR) Number: 6604
Related CR Release Date: August 28, 2009
Related CR Transmittal Number: R1804CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1804, CR 6604

Activation of new coordination of benefits agreement trading partner dispute error code

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6640, which conveys a new coordination of benefits agreement (COBA) trading partner dispute error code that the coordination of benefits contractor (COBC) will return to Medicare contractors when certain claims are not accepted by supplemental payers. Billing staff should be aware of this change.

Background

The COBC consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) developed and further refined the COBC detailed error report process through the issuance of CR 3709 (See Transmittals 474, dated February 11, 2005, on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf*) and CR 5472 (See Transmittal 1189 dated February 28, 2007, on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/Downloads/R1189CP.pdf*).

Under the COBC detailed error report process, the COBC reports to Medicare contractors, via a standard detailed error report layout, any of the following error conditions that resulted in their claims not being crossed over:

- Incoming flat file contained structural problems ("111" flat file errors)
- Incoming flat file contained claims with Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) compliance errors ("222" errors), and
- The COBA trading partner rejected the contractors' claims ("333" trading partner dispute errors).

Note: Crossover is the transfer of processed claim data from Medicare operations to commercial insurance companies that sell supplemental insurance benefits to Medicare beneficiaries and to Medicaid (or state) agencies.

Depending upon the error percentage encountered in association with errored claims, Medicare contractors then, after five business days, automatically generate special provider notification letters informing the affected physician/supplier/provider that the beneficiary's claim(s) cannot be crossed over.

In earlier instructions CMS directed Medicare contractors to suppress creation of their standard provider notification letters when they receive any of the following "333" dispute reason codes via the COBC detailed error reports:

00100 – duplicate claim

000110 – duplicate claim within the same ISA-IEA loop, and

000120 – duplicate claim within the same ST-SE loop.

CMS made this decision primarily for two reasons:

1. It was believed that these particular error conditions were out of the control of the billing provider.
2. It would be futile for the provider to bill the claims to the COBA trading partner outside the crossover process given that the entity had already received the claim, as witnessed by its lodging of a dispute on the basis of duplicate claim receipt.

Currently, the only in-use "333" dispute codes that will trigger provider notification letters are the following: 000200 – claim for provider ID/state should have been excluded

000300 – beneficiary not on eligibility-file

000500 – incorrect claim count; 000600—claim does not meet selection criteria

000700 – HIPAA error

009999 – other

Through CR 6640, the COBC will activate dispute reason code 000400 (previously reserved for future use) as a new "333" trading partner dispute code. As a result of this action, the COBC will:

1. Transmit error code 000400 to Medicare contractor when indicated via the COBC detailed error report, and
2. Include within the error description field on the COBC Detailed Error Report the following standard message: "No provider agreement with Medicaid/other payer; claims crossover not possible."

Also, as a result of CR 6640, all Medicare contractors will generate error code 000400 when received via their COBC detailed error report with accompanying error message on their outgoing notification letters to providers, physicians, or suppliers. As indicated in CR 6640, upon receipt of the contractor-generated special letters, affected providers, physicians, or suppliers may wish to contact their patient's indicated supplemental payer to determine next steps.

Activation of new coordination of benefits agreement trading partner dispute error code (continued)

Additional information

The official instruction, CR 6640, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R562OTN.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6640
Related Change Request (CR) Number: 6640
Related CR Release Date: September 25, 2009
Related CR Transmittal Number: R562OTN
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

Source: CMS Pub. 100-20, Transmittal 562, CR 6640

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
November 2009 – January 2010

Topic – Direct Data Entry

When: Monday, November 16, 2009

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Part A Appeals

When: Tuesday, December 8, 2009

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Hot Topics

When: Tuesday, January 12, 2010

Time: 11:30 p.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training Web site at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time User?** Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Tips for using the FCSO provider training Web site

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

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

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

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____
Registrant's Title: _____
Provider's Name: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____
Provider Address: _____
City, State, ZIP Code: _____

Keep checking our Web site, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers. ❖

PREVENTIVE SERVICES

October is Healthy Lung Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered smoking and tobacco-use cessation counseling benefits.

Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can attribute to and exacerbate heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysm, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Medicare provides coverage of smoking and tobacco-use cessation counseling for beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use, or who take certain therapeutic agents whose metabolism or dosage is affected by tobacco use.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by educating them about their risk factors and encourage them to take advantage of Medicare covered smoking and tobacco-use cessation counseling benefits as appropriate.

For more information

CMS has developed several educational products related to Medicare-covered smoking and tobacco-use cessation counseling:

- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including smoking and tobacco-use cessation counseling.

  http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

- The MLN preventive services educational products Web page – provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products, including products related to Medicare-covered smoking and tobacco-use cessation counseling.

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

- Quick Reference Information: Medicare Preventive Services -- this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling.

  http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

- Smoking and Tobacco-Use Cessation Counseling Services – this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling.

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

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information about the risks of smoking and resources to help encourage your patients to quit, please visit the American Lung Association "Quit Smoking" Web site at *http://www.lungusa.org/stop-smoking/*.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of smoking and tobacco-use cessation counseling services and other preventive services covered by Medicare. ❖

Source: CMS PERL 200910-24

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

OTHER EDUCATIONAL RESOURCES

Revised rural health publications

The following rural health publications are now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The revised rural health bookmark (April 2009), which provides information about educational resources that are available to the rural health community, is available in downloadable and print formats.
- The rural health fact sheet series (Summer 2009), which provides information about rural facility types and coverage and payment policies, is available in CD-ROM format. The following publications are included in the fact sheet series:

  Critical access hospital

  Federally qualified health center

  Medicare dependent hospital

  Medicare disproportionate share hospital

  Rural health clinic

  Rural referral center

  Sole community hospital

  Swing bed

  Telehealth services

To access the downloadable version of the rural health bookmark, visit *http://www.cms.hhs.gov/MLNProducts/downloads/Ruralbookmark.pdf*.

To place your order for the print version of the rural health bookmark or the rural health fact sheet series CD-ROM, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200910-15

Revised Medicare Learning Network publications

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

- *The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2009) offers general information about the Medicare Program, how to become a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and fee-for-service appeals. This publication may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf*.
- *The Facilitator's Guide: Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2009) includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program including instructions for facilitators, customization guide, a PowerPoint presentation with speaker notes, pre- and post-assessments, master assessment answer keys, and a course evaluation tool. This publication may be accessed at *http://www.cms.hhs.gov/MLNProducts/Downloads/facilitators_guide.zip*. ❖

Source: CMS PERL 200910-33

Message from the Medicare Learning Network

The Centers for Medicare & Medicaid Services (CMS) has revised and updated the following educational resources documents:

- **The 2009-2010 seasonal influenza educational products and resources**
  This document provides a list of MLN products and other resources with information about Medicare policies regarding seasonal flu, has been newly revised and updated. It is now available on the *Medicare Learning Network* in a downloadable, printable format at the following address: *http://www.cms.hhs.gov/MLNProducts/Downloads/Flu_Products.pdf*.

  For more information about Medicare coverage of the seasonal influenza vaccine and its administration as well as the many other preventive services Medicare covers, please go to the CMS Web site *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

  For information on Medicare policies related to H1N1 influenza, please go to the CMS Web site at *http://www.cms.hhs.gov/H1N1*.

- **Adult immunization**
  This educational brochure provides information about Medicare coverage of the seasonal influenza, pneumococcal, and hepatitis B vaccines. It is now available on the Medicare Learning Network in a downloadable, printable format at the following address: *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.

  Printed hardcopy versions of this brochure will be available at a later date. For more products related to Medicare-covered preventive services, please visit our preventive services educational products Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

  Note: The information in the adult immunizations brochure relates to seasonal influenza only. For information related to Medicare coverage and policy related to H1N1 influenza, also called "swine flu," please visit the CMS Web site at *http://www.cms.hhs.gov/H1N1*.

- **Glaucoma screening**
  This educational brochure provides information about Medicare coverage of glaucoma screenings, including dilated eye examinations with an intraocular pressure measurement, direct ophthalmoscopy examinations and slit-lamp biomicroscopic examinations. It is now available on the *Medicare Learning Network* in a downloadable, printable format at the following address: *http://www.cms.hhs.gov/MLNProducts/downloads/Glaucoma.pdf*.

  Printed hardcopy versions of this brochure will be available at a later date. For more products related to Medicare-covered preventive services, please visit our preventive services educational products Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

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

Source: CMS PERL 200910-24

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

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 2009 through September 2010.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

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

Mail this form with payment to:

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

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
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

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

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and 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

PROVIDER ENROLLMENT
American Diabetes Association Certi cates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

SPECIAL DELIVERY
Overnight Mail and/or other Special Courier Services
First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

Other Important Addresses

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

PROVIDER EDUCATION & OUTREACH
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

Medicare Web sites

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

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

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

REDETERMINATION and REDETERMINATION OVERPAYMENTS
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

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

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

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and 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

PROVIDER ENROLLMENT
American Diabetes Association Certi cates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

SPECIAL DELIVERY
Overnight Mail and/or other Special Courier Services
First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

Other Important Addresses

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

PROVIDER EDUCATION & OUTREACH
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

Medicare Web sites

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

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

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦