

Communiqué

Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Items of Importance

**GUIDELINES TO ALLOW CONTRACTORS TO DEVELOP AND
UTILIZE PROCEDURES FOR ACCEPTING AND PROCESSING
APPEALS VIA FACSIMILE AND/OR VIA A SECURE INTERNET
PORTAL/APPLICATION**
~CMS MLN Matters~

MLN Matters® Number: MM6958
Related CR Release Date: June 11, 2010
Related CR Transmittal #: R1986CP

Related Change Request (CR) #: 6958
Effective Date: October 1, 2010
Implementation Date: October 1, 2010

Provider Types Affected

This article is for physicians, providers, and suppliers submitting Medicare fee-for-service (FFS) claim appeal requests to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed***STOP – Impact to You***

This article is based on Change Request (CR) 6958 which updates the current instructions in the Medicare Claims Processing Manual, Chapter 29, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application.

CAUTION – What You Need to Know

CR 6958 provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via facsimile and/or via a secure Internet portal/application. At this time, Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must seek approval from the Centers for Medicare & Medicaid Services (CMS) prior to implementation of that portal/application.

GO – What You Need to Do

Note that, even if your contractor allows submission of appeal requests via facsimile and/or via a secure Internet portal/application, the decision to use those venues is yours. Your contractor may not require you to use those venues. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Several Medicare contractors have requested authority from the CMS to utilize a secure Internet portal/application to receive and process Medicare FFS claim appeal requests. In addition, several Medicare contractors have begun to accept claim appeal requests received in writing via facsimile.

CR 6958 provides guidance regarding appeal requests received in writing via facsimile or via a secure Internet portal/application, and it provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via these mechanisms.

The purpose of CR 6958 is to update the current instructions in the Medicare Claims Processing Manual, Chapter 29 (Appeals of Claims Decisions), to allow Medicare contractors to accept appeal requests via facsimile and/or via a secure Internet portal/application.

CMS does not require its contractors to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application is at the discretion of the appellant. Contractors will continue to accept appeal requests in hard copy via mail. Key portions of CR 6958 for providers are as follows:

What Constitutes a Request for Redetermination

Written Requests for Redetermination Submitted by a State, Provider, Physician or Other Supplier

States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile (if the contractor chooses to receive requests via facsimile), or, where available, secure Internet portal/application indicating what they are appealing and why. The acceptable written ways of doing this are via:

- **A completed Form CMS-20027 (constitutes a request for redetermination).**
The contractor supplies these forms upon request by an appellant. "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request.
- **& A written request not on Form CMS-20027.**
At a minimum, the request shall contain the following information:
 - Beneficiary name;
 - Medicare health insurance claim (HIC) number;
 - The specific service(s) and/or item(s) for which the redetermination is being requested;
 - The specific date(s) of the service; and
 - The name and signature of the party or the representative of the party.

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

- **& A secure Internet portal/application.** If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall

include the required elements for a valid appeal request as outlined under Chapter 29, Section 310.1.B.2.b which is attached to CR 6958.

NOTE: Some redetermination requests may contain attachments. For example, if the Remittance Advice (RA) is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Requirements for a Valid Signature on an Appeal Request:

For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- A **written signature** may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An **electronic, digital, and/or digitized signature** is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, "electronically signed by" or "verified/approved by" etc.
- A **stamp signature or other indication that a "signature is on file"** on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request **shall not** be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

How Contractors will Handle Multiple Requests for Redetermination for the Same Item/Service:

If a contractor receives multiple timely requests for redetermination for the same item or service from either multiple parties or via multiple venues (i.e., hard copy mail, facsimile, or via a secure Internet portal/application) the contractor acts as follows:

- If a decision or dismissal notice has already been issued or the claim for the item/service at issue has been adjusted/paid in accordance with the redetermination decision and the contractor receives additional redetermination request(s) for the same items/services, the contractors will treat the additional request as an inquiry. Contractors **shall not** issue a dismissal notice.

Note: In accordance with the Medicare Claims Processing Manual (Chapter 29, Section 310.6.3 which is attached to CR6958), if an appellant requests that the contractor vacates its dismissal action and the contractor determines that it cannot vacate the dismissal; it sends a letter notifying the appellant accordingly. The contractor shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request.

- If a decision or dismissal notice has not been issued (i.e., the appeal is pending), and the claim for the items/services at issue has not been otherwise adjusted/paid following the redetermination decision, then upon receipt of

additional redetermination request(s) for the same items/services, the contractor shall:

1. Combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with the requirements as outlined in 42 CFR 405.944(c). See <http://edocket.access.gpo.gov/cfr/2009/octqtr/pdf/42cfr405.944.pdf> on the Internet.
 2. When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that multiple requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the appellant that the decision or dismissal was issued timely in accordance with 42 CFR 405.944(c).
- & If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting multiple requests for redetermination via multiple venues, the contractor shall take additional steps to educate the appellant regarding the appeals process.

Timely Processing Requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of the Medicare Claims Processing Manual, Chapter 29, Section 310.4(D)(4), which is attached to CR 6958). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties. Affirmations processed via a CMS approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application.
2. For partial reversals and full reversals, when all of the following actions have been completed:
 - The decision letter, if applicable, is mailed to the parties (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application), and
 - & The actions to initiate the adjustment action in the claims processing system are taken.
3. For withdrawals and dismissals, the date that the dismissal notice is mailed (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application) to the parties.

The Redetermination Decision

The law requires contractors to conclude and mail and/or otherwise transmit, as noted below, the redetermination within 60 days of receipt of the appellant's request, as indicated in the Medicare Claims Processing Manual, Chapter 29, Section 310.4, which is attached to CR 6958. For unfavorable redeterminations, the contractor mails the

decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and appointed representative, if applicable).

Contractors shall provide the decision, as required below; in writing via hard copy mail (unless the contractor has submitted a request and received approval for use of secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically). Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism.

Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities

Contractors who develop and utilize a secure Internet portal/application for appeals purposes will ensure, at a minimum:

- CMS approves the proposed portal/application and usage prior to development and implementation.
- & Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request (the system must include verbiage instructing the appellant not to submit additional redetermination requests for the same item/service via a different venue).
- & The secure Internet portal/application includes a formal registration process that validates the signature and requires, at a minimum, use of restricted user IDs and passwords.
- & Templates for submission of electronic appeal requests must include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- & Contractors utilizing an approved portal/application must provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- & Contractors must also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.
- & Contractors utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- & Redetermination decision and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements. In addition, contractors shall provide hard copy decision and/or dismissal notices to parties to the appeal and who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- & Contractors will also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on

any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

Additional Information

The official instruction, CR 6958, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R1986CP.pdf> on the CMS website.

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

SIGNATURE GUIDELINES FOR MEDICAL REVIEW PURPOSES

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6698 Revised
Related CR Release Date: March 16, 2010
Related CR Transmittal #: R327PI

Related Change Request (CR) #: 6698
Effective Date: March 1, 2010
Implementation Date: April 16, 2010

Note: This article was revised on June 16, 2010 to include on pages 6-7 a table excerpted from CR 6698 that summarizes signature requirements. All other information is the same.

Provider Types Affected

This article is for physicians, non-physician practitioners, and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Carriers, Regional Home Health Intermediaries (RHHIs), and/or Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for E-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010. **Please note that all signature requirements in CR 6698 are effective retroactively for Comprehensive Error Rate Testing (CERT) for the November 2010 report period.**

Background

Those contractors who review Medicare claims include MACs, Affiliated Contractors (ACs), the CERT contractors, Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the Program Integrity Manual (PIM) required a “legible identifier” in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds E-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the Medicare Benefit Policy Manual, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g. MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements: If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT **shall disregard the order** during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.

- & **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- & For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered. **EXAMPLE:** The claim selected for review is for a hospital visit on October 4. The Additional Documentation Request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.
- & **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- & **Definition of an Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- & Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement: "I, _____[print full name of the physician/practitioner]____, hereby attest that the medical record entry for _____[date of service]____ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]____ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."
- & While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- & Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- & If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.

- & Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- & The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
 - In the situations where the guidelines indicate “**signature requirements met**,” the reviewer will consider the entry.
 - & In situations where the guidelines indicate “**contact provider and ask a non-standard follow up question**,” the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
 - & In the situations where the guidelines indicate “**signature requirements NOT met**,” the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified E-Prescribing system. For Medicare Part B medical review purposes, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, *42 CFR 423.160 Standards for Electronic Prescribing*, you may go to http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf on the Internet.
- & When Part B drugs, other than controlled substances, have been ordered through a qualified E-Prescribing system, the reviewer will NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- & At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any E-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.
- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified E-Prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.

Additional Information

CR 6698 includes a helpful table that summarizes the situations where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit an attestation statement or signature log. Key portions of that table are as follows:

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: 1) a signature log, or 2) an attestation statement	X	
6	Illegible Signature NOT over a typed/printed name, NOT on letterhead and the documentation is UNaccompanied by: a) a signature log, or b) an attestation statement	X	
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but accompanied by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name UNaccompanied by: a) a signature log, or b) an attestation statement	X	
10	Unsigned typed note with provider's typed name Example: John Whigg, MD	X	
11	Unsigned typed note without providers typed/printed name	X	

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
12	Unsigned handwritten note, the only entry on the page	X	
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	“signature on file”		X

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

The official instruction, CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R327PI.pdf> on the CMS website.

Legacy Providers Only**WISCONSIN PHYSICIANS SERVICE (WPS) LEGACY PROVIDER
TRANSITION TO JURISDICTION 4 (J4) MEDICARE
ADMINISTRATIVE CONTRACTOR (MAC)**

Effective October 18, 2010, most Wisconsin Physicians Service (WPS) Part A providers located in Colorado, New Mexico, Oklahoma, and Texas will transition to TrailBlazer Health Enterprises®, the Jurisdiction 4 (J4) A/B Medicare Administrative Contractor (MAC) for all Medicare processes including:

- Claims processing.
- Provider enrollment activities.
- Provider audit and reimbursement activities.
- Customer Service/Provider Contact Center.
- Redetermination requests (first-level appeals).
- Education needs of the provider community.

This change is being made at the direction of the Centers for Medicare & Medicaid Services (CMS) and is consistent with a regulation that requires that most providers be assigned to A/B MACs based on their geographic location.

A limited subset of Medicare chain providers in these states, known as Qualified Chain Providers (QCPs), may not be transferred to the J4 A/B MAC to facilitate the chain's ability to bill only one MAC. CMS considers the location of the QCP's "home office" when assigning providers to A/B MACs. If you are a hospital (including a Critical Access Hospital (CAH)) or Skilled Nursing Facility (SNF) within the J4 states listed above and are a member of a chain, check with your home office to determine if the chain has received a QCP approval letter from CMS. In addition, a limited number of QCPs have corporate home offices within the J4 A/B MAC region. To facilitate the chain's ability to bill only one MAC, their facilities in other states may transition to TrailBlazerSM.

TrailBlazer J4 WPS Transition Website

TrailBlazer has created a dedicated J4 WPS Transition website to ensure providers receive the latest information, important updates, and answers to Frequently Asked Questions (FAQs) throughout the workload implementation. This site will be continually updated with pertinent J4 legacy transition information as soon as it becomes available. The J4 WPS Transition website can be accessed at:

<http://www.trailblazerhealth.com/j4wps/>

Future transition information will be released as soon as it becomes available. TrailBlazer will be partnering with CMS and WPS to coordinate all transition activities and provider outreach information.

TrailBlazer J4 WPS Transition Listserv – Register Now

All impacted providers are encouraged to register early for the TrailBlazer J4 WPS Transition listserv. This will ensure transitioning providers receive pertinent J4 MAC e-mail messages regarding transition details such as TrailBlazer connectivity options, educational opportunities,

J4 Local Coverage Determination (LCD) policies, cutover dates, and other important claims processing changes. Please share this information with anyone who might benefit from receiving this information and encourage them to subscribe. To register, click **LISTSERV** from the top navigation on the J4 WPS Transition website and follow the instructions.

Avoid Disruption in Payment – Participate in GPNET Migration/Early Boarding – Claim Submission

The ability to transition to GPNet, the TrailBlazer front end, prior to the cutover date is a tried-and-true TrailBlazer option called “early boarding,” and it is a proven means of mitigating disruption in Electronic Data Interchange (EDI) services during workload and/or systems transitions. TrailBlazer has established the interfaces to the WPS FISS claims processing system, and all claims submitted to TrailBlazer will be processed just as if they were submitted to the WPS front-end system. All affected providers **must** be transitioned to TrailBlazer by the cutover date of October 18, 2010. TrailBlazer strongly encourages all impacted providers to make the necessary changes and begin performing all EDI activity with TrailBlazer during this early boarding period.

Date	EDI Transition Schedule
09/01/10	Last day EDI enrollments and all requests for EDI products and services will be completed by WPS.
09/17/10	Last day WPS will accept requests for new DDE IDs, with the exception of termination requests.
10/13/10*	Last day TrailBlazer will accept claims from providers with the old contractor number. After this time, all claims submitted to TrailBlazer must contain the new contractor number.
10/14/10*	Last day WPS will accept claims from transitioning providers.
10/14/10*	The 10/14/10 cycle will be a payment cycle. If you have not submitted production claims to TrailBlazer, your electronic remittances (ERAs) will need to be downloaded from your WPS mailbox. If you are already submitting to TrailBlazer, your remittances should be downloaded from TrailBlazer.
10/15/10*	DARK DAY! TrailBlazer will receive and hold all claims noting the appropriate receipt date.
10/18/10*	DARK DAY! TrailBlazer will receive and hold all claims noting the appropriate receipt date.
10/19/10*	DARK DAY! TrailBlazer will receive and hold all claims noting the appropriate receipt date.
10/20/10*	Day one of production! All held claims will be processed by TrailBlazer with the appropriate receipt date.

**These dates are subject to change – any/all changes will be announced via the J4 WPS Transition website.*

Updated CMS-588 Electronic Funds Transfer (EFT) Agreements

Transitioning providers with existing EFT agreements with the current fee-for-service contractor are required to submit an updated CMS-588 authorization agreement form for EFT to TrailBlazer. Providers who fail to submit an EFT agreement to TrailBlazer by **October 1, 2010**, may experience possible payment delays and/or disruption in their electronic claim payments.

Visit the J4 WPS EDI web page at <http://www.trailblazerhealth.com/J4WPS/EDI/> for important EDI resources such as FAQs, EDI/Early Boarding Letter, EDI Enrollment Packet, EFT Letter, ERA Request Form, and various manuals. For assistance or questions related to this transition, GPNet or DDE connectivity, claim submission, report retrieval, and general EDI-related questions, please contact the TrailBlazer EDI Technology Support Center toll-free at (866) 749-4302 for assistance Monday through Friday, 8 a.m. – 6 p.m. ET.

Important Letters, Resources and Education Opportunities

TrailBlazer and WPS will make every effort to ensure that providers continue to receive quality Medicare services throughout the transition period. Affected providers should watch their mail for the following important letters, also available on the TrailBlazer website, which will provide information regarding the J4 WPS transition:

- Welcome to TrailBlazer
<http://www.trailblazerhealth.com/Publications/Job%20Aid/WPSWelcomeLetter.pdf>
- TrailBlazer Electronic Data Interchange (TBEDI)
<http://www.trailblazerhealth.com/Publications/Job%20Aid/WPSEDIletter.pdf>
- Electronic Funds Transfer (EFT)
<http://www.trailblazerhealth.com/Publications/Job%20Aid/WPSEFTLetter.pdf>

TrailBlazer has posted a full schedule of J4 WPS Transition Web-Based Trainings (WBTs) and Talk-to-TrailBlazer Teleconferences (TTTs) to the J4 WPS Calendar of Events web page. These sessions will address transition issues/differences, connectivity, payment concerns, LCD issues, and answer transition-related questions. Visit the Calendar of Events today at <http://www.trailblazerhealth.com/Calendar/> to register for these valuable education opportunities.

More information is available in the following resources:

- J4 MAC Part A WPS Legacy Transition Guide
<http://www.trailblazerhealth.com/Publications/Job%20Aid/TransitionGuide.pdf>
- New TrailBlazer J4 Part A WPS Transition Website
<http://www.trailblazerhealth.com/Publications/Job%20Aid/J4WPSWebSite.pdf>
- Provider Checklist for a Successful WPS Transition
<http://www.trailblazerhealth.com/Publications/Job%20Aid/ProviderChecklist.pdf>

In addition, WPS transition-related FAQs/responses can be viewed on the J4 WPS FAQs page at <http://www.trailblazerhealth.com/Tools/FAQs.aspx>. Providers may submit all inquiries to the J4 WPS inquiry e-mail address at:

j4awps@trailblazerhealth.com

MAC Providers Only (IA, KS, MO, NE)
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HARD COPY COMMUNIQUÉ SUBSCRIPTION

WPS Medicare will offer *Communiqué* subscriptions in hard copy format for Fiscal Year 2011 (which runs from October 2010 through September 2011) **for those providers without Internet access**. The cost for the subscription to the Fiscal Year 2011 hard copy *Communiqué* is \$60.00. You will receive your hardcopies at the end of each quarter (December 2010, March 2011, June 2011, and September 2011).

WPS Medicare would like to take this opportunity to remind you that you can avoid additional costs by finding all the information in the hard copy newsletter free on our website at <http://www.wpsmedicare.com/j5macparta/publications/communique/>.

If you would like to receive the *Communiqué* newsletter in hard copy format, please complete and return the following order form along with your check to "WPS Medicare."

Provider Name: _____
Attn: _____
Address: _____ PO Box/Suite: _____
City: _____ State: _____ Zip: _____
Telephone: _____

Orders must be pre-paid and check made payable to **WPS Medicare**.

Send check or money order to:

WPS Medicare '
Medicare Publications '
PO Box 999 '
Marion, IL 62959 '

Claim Submission**COMMON WORKING FILE (CWF) OVERRIDE EDIT FOR KIDNEY TRANSPLANT DONOR CLAIMS WHEN THE KIDNEY RECIPIENT IS DECEASED**

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6978 Revised
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R2008CP

Related Change Request (CR) #: 6978
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: This article was revised on August 6, 2010, to reflect a revised CR 6978, which was re-issued on August 5, 2010. The article was revised to include Regional Home Health Intermediaries (RHHIs) in the Section listing provider types affected. All other information is the same.

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare carriers, fiscal intermediaries (FIs), RHHIs, or Part A/B Medicare Administrative Contractors (A/B MACs) for live kidney donor and related services for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6978 which instructs Medicare contractors to override certain edits on claims for donor expenses when the kidney recipient is deceased. Please make sure your billing staff is aware of these changes.

Background

Medicare instructions allow donor expenses incurred after the death of the kidney recipient to be treated as incurred before the death of the kidney recipient. However, some of these claims are being rejected by Medicare systems. CR6978 corrects this problem for services performed on or after January 1, 2011.

Key Points of CR 6978:

- & All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- & All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number). Modifier Q3 (Live Kidney Donor and Related Services) must appear on the claim.
- & For institutional claims which do not require modifiers, Medicare contractors may process the claim when the donor is receiving institutional services related to the donation of the kidney where the transplant recipient has died and the donor receives those services subsequent to the recipient's death.

Additional Information

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

The official instruction (CR6978) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.gov/Transmittals/downloads/R2008CP.pdf> on the CMS website.

DIALYSIS ADEQUACY, INFECTION AND VASCULAR ACCESS REPORTING

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6782 Revised
Related CR Release Date: March 17, 2010
Related CR Transmittal #: R1932CP

Related Change Request (CR) #: 6782
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: This article was revised on May 27, 2010, to add a note at the bottom of page 4 regarding the use of HCPCS 90999 in dialysis revenue code lines in order to report the required infection modifiers. All other information remains the same.

Provider Types Affected

Renal Dialysis Facilities (RDFs) submitting claims to Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries are impacted by this issue.

Provider Action Needed***STOP – Impact to You***

Renal Dialysis Facilities (RDFs) need to know that CR 6782 requires new quality data reporting for dialysis adequacy, infection and vascular access on **all End Stage Renal Disease (ESRD) claims and all ESRD Hemodialysis claims with dates of service on or after July 1, 2010.**

CAUTION – What You Need to Know

The new data reporting will allow the Centers for Medicare & Medicaid Services (CMS) to implement an accurate **quality incentive payment for dialysis providers** by January 1, 2012, as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153c.

GO – What You Need to Do

Make sure that your billing staffs are aware of these new reporting and claim requirements described below.

Background

This article is based on CR 6782, which explains that section 153c of the MIPPA requires CMS to implement a quality based payment program for dialysis services effective January 1, 2012. CMS currently collects two monthly measurements of quality of care via the ESRD

claims submitted by dialysis providers: hemoglobin or hematocrit as a measure of anemia management and urea reduction ratio (URR) as a measure of hemodialysis adequacy.

The source data for the two current quality measures are collected on dialysis provider claims. The anemia management quality measure uses the most recent hemoglobin or hematocrit lab value, collected using value codes 48 or 49 on bill type 72x. The hemodialysis adequacy measure uses the current month's urea reduction ratio (URR) lab value, collected using Healthcare Common Procedure Coding Systems (HCPCS) modifiers G1 through G6 on hemodialysis line items (revenue center 082x and HCPCS 90999).

These two quality measures meet the minimum requirements as mandated in MIPPA section 153c. However, the URR measure of dialysis adequacy does not provide data for the entire ESRD dialysis population. Not having dialysis adequacy data for a segment of the dialysis population (peritoneal dialysis patients) is problematic in the development of a quality based payment program that will decrease provider payment by up to 2% based on quality outcome data because, with the missing data, CMS will not be able to assess all ESRD dialysis providers based on the same criteria.

MIPPA section 153c also requires the use of quality measures endorsed by a consensus organization. CMS recently reexamined and received National Quality Forum (NQF) endorsement for the ESRD quality measures. Both CMS and NQF found that dialysis adequacy is best measured by Kt/V (K-dialyzer clearance of urea; t-dialysis time; V-patient's total body water) for both hemodialysis and peritoneal dialysis patients. The NQF granted time-limited endorsement of URR for hemodialysis patients and recommended that CMS drop it in favor of Kt/V as soon as possible. While dialysis adequacy is measured monthly for in-center hemodialysis patients, dialysis adequacy is measured less frequently for peritoneal dialysis patients (at least every four months). Therefore, it is necessary to track both the date of the most recent measurement and the result of the most recent measurement.

Finally, MIPPA section 153c provides for the use of additional quality measures for the quality based payment program as determined by the Secretary of Health and Human Services. Two additional quality measures could easily be collected using HCPCS modifiers for hemodialysis patients to record vascular access. The first measure is use of an arteriovenous fistula with two needles, which is recognized as the best vascular access because it is associated with the least infections. The second measure is the use of any vascular catheter, which is recognized as the worst vascular access because it is associated with the most infections. Collecting vascular access data will allow CMS to develop a more robust quality based payment program in order to implement national policy without additional data collection burden on dialysis providers, who are already required to collect these data under the Fistula First Initiative.

Consequently, CMS will require the reporting of the Kt/V reading and date of the reading, vascular access and infection data on ESRD claims with dates of service on or after July 1, 2010. This new data reporting requirement will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by MIPPA, section 153c. The July 2010 implementation date is needed because the quality incentive payment must be in part based on provider improvement over time; thus, CMS requires an accurate measurement of baseline provider performance. The CMS will require that providers continue to report the existing G1 through G6 modifiers for URR at this time.

New quality data required on All ESRD claims with dates of service on or after July 1, 2010:

Claim level codes:

- & **Value code D5:** Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the claim date of service.
- & **Occurrence code 51:** Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the claim date of service.

In the event that the provider has not performed the Kt/V test for the patient, the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. The occurrence code date should not be reported on the claim in the case of no Kt/V reading being reported. For dates of service on or after July 1, 2010, failure to report the D5 value code on the 72x bill type will result in the claim being returned to the provider. Also, Medicare will return 72x bill types with dates of service on or after July 1, 2010 to the provider if the claim does not contain occurrence code 51, except where there is a D5 value code with 9.99.

Line level codes to be reported on dialysis revenue code lines:

- & **Modifier V8:** Dialysis access-related infection present (documented and treated) during the billing month. Reportable dialysis access-related infection is limited to peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients. Facilities must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) if identified during the billing month. For individuals that receive different modalities of dialysis during the billing month and an infection is identified, the V8 code should only be indicated on the claim for the patient's primary dialysis modality at the time the infection was first suspected. Non-access related infections should not be coded as V8. If no dialysis-access related infection is present by this definition, providers should instead report modifier V9.
- & **Modifier V9:** No dialysis-access related infection, as defined for modifier V8, present during the billing month. Dialysis access-related infection, defined as peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients must be reported using modifier V8. Providers must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) using modifier V8.

Note: Medicare systems will return to the provider 72x bill types with dates of service on or after July 1, 2010 when either the modifier V8 or V9 is not present on each dialysis revenue code line (0821, 0831, 0841, or 0851). Providers may report HCPCS 90999 in all dialysis revenue code lines in order to report the required infection modifiers.

New quality data required on All ESRD Hemodialysis claims with dates of service on or after July 1, 2010:

Line level codes to be reported on hemodialysis revenue code lines:

Vascular Access for ESRD Hemodialysis Patients – An indicator of the type of vascular access used for the delivery of hemodialysis at the last hemodialysis session of the month. The code is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.

- **Modifier V5:** Any Vascular Catheter (alone or with any other vascular access)
- **Modifier V6:** Arteriovenous Graft (or other vascular access not including a vascular catheter)
- **Modifier V7:** Arteriovenous Fistula Only (in use with two needles)

Note: Medicare systems will return to the provider 72x bill types with dates of service on or after July 1, 2010 billing for hemodialysis when the latest line item date of service billing for revenue code 0821 does not contain one of the following modifiers: V5, V6, or V7.

The modifiers V5-V9 are effective January 1, 2010, and the Medicare Integrated Code Editor has been updated to allow the reporting of these codes for claims with dates of service on or after January 1, 2010. Therefore, providers may voluntarily report these modifiers for claims with dates of service January 1, 2010 through July 1, 2010.

Additional Information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI or A/B MAC, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1932CP.pdf> on the CMS website.

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

The Medicare Learning Network Catalog of Products contains a fact sheet *Outpatient Maintenance Dialysis— End-Stage Renal Disease Fact Sheet*, which provides general information about Outpatient Maintenance Dialysis for ESRD, the composite payment rate system, and separately billable items and services. The fact sheet is available at <http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymfctsh08-508.pdf> on the CMS website.

DISCARDED DRUGS AND BIOLOGICALS UPDATES**~ Revised CMS MLN Matters ~**

MLN Matters® Number: MM6711 Revised
Related CR Release Date: April 30, 2010
Related CR Transmittal #: R1962CP

Related Change Request (CR) #: 6711
Effective Date: July 30, 2010
Implementation Date: July 30, 2010

Provider Types Affected

Physicians, hospitals, suppliers and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Part A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying drugs and biologicals should review this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6711 to include in the Medicare Claims Processing Manual the updated policy, which describes when to use the JW modifier for discarded drugs.

Background

As a reminder, your Medicare contractor may require its providers to use the JW modifier. If required, when billing Medicare for all drugs except those provided under the Competitive Acquisition Program for Part B drugs and biologicals, use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the discarded drug or biological.

For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining 5 units will be billed and paid on another line using the JW modifier. The JW modifier is only applied to units not used. **NOTE:** Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information

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

The official instruction, CR6711, issued to your Medicare FI, carrier, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1962CP.pdf> on the CMS website.

ENHANCEMENTS TO HOME HEALTH (HH) CONSOLIDATED BILLING ENFORCEMENT

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6911 Revised
Related CR Release Date: June 14, 2010
Related CR Transmittal #: R1988CP

Related Change Request (CR) #: 6911
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Note: This article was revised on June 14, 2010, to reflect the revised CR 6911 that was issued on that date. In this article, the CR release date and transmittal number (see above) were revised. Also, the web address for accessing CR 6911 was revised. All other information remains the same.

Provider Types Affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What You Need to Know

Consolidated Billing Edit Modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the Medicare Claims Processing Manual, chapter 10, section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the 'from' date on the supply line item falls within a HH episode.

A New File of HH Certification Information

Chapter 10, section 20.1 of the Medicare Claims Processing Manual describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

- G0179 Physician Re-certification For Medicare-covered Home Health Services Under A Plan of Care
- G0180 Physician Certification For Medicare-covered Home Health Services Under A Plan of Care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60% or 50% payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's Common Working File (CWF) query screens, Medicare systems will display all certification code dates within 9 months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within 9 months before the current date as the default response.

NOTE: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40% of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional Information

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

The official instruction (CR6911) issued to your Medicare RHHI/MAC is available at <http://www.cms.gov/Transmittals/downloads/R1988CP.pdf> on the CMS website.

**JULY 2010 INTEGRATED OUTPATIENT CODE EDITOR (I/OCE)
SPECIFICATIONS VERSION 11.2**

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6967 Revised
Related CR Release Date: June 4, 2010
Related CR Transmittal #: R1982CP

Related Change Request (CR) #: 6967
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: This article was revised on June 7, 2010, to reflect the revised CR 6967 that was issued on June 4. To reflect the CR changes in this article, the descriptions for HCPCS 90664, 90666, 90667, 90668, and 90670 on page 4 were revised. Also, the CR release date, transmittal number, and the web address for accessing CR 6967 were revised. All other information remains the same.

Provider Types Affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System (HHPPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider Action Needed

This article is based on Change Request (CR) 6967, which describes changes to the I/OCE and OPPS to be implemented in the July 2010 OPPS and I/OCE updates. Be sure billing staffs are aware of these changes.

Background

CR 6967 describes changes to billing instructions for various payment policies implemented in the July 2010 OPPS update. The July 2010 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR 6967.

Note: The full list of I/OCE specifications can now be found at <http://www.cms.gov/OutpatientCodeEdit/> on the Centers for Medicare & Medicaid Services (CMS) website.

A summary of the changes for July 2010 is within Appendix M of Attachment A of CR 6967 and that summary is captured in the following key points.

Key Points of CR 6967 Based on Appendix M of the I/OCE Specifications

- Effective October 1, 2003, Medicare will delete edit 59.
- Effective January 1, 2008, Medicare will apply modified edit 74 to Type of Bill (TOB) 85x with Revenue Codes 96x, 97x, or 98x.
- Effective March 23, 2010, Medicare will apply a mid-quarter date and associated edit to codes as necessary.
- Effective July 1, 2010, Medicare will:
 - Modify the I/OCE interface for Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 to: a) Increase the number of diagnosis codes up to 28, and the field size to 8 bytes, input & output; b) Increase the number of condition codes up to 11; and c) Add a new 1-byte field for Code Type indicator;
 - Make Healthcare Common Procedure Coding System/Ambulatory Payment Class/Status Indicator (HCPCS/APC/SI) changes (data change files);
 - Implement version 16.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers) (Edits 19, 20, 39 and 40 are affected); and
 - Create 508-compliant versions of the Specifications & Summary of Data Changes documents for publication on the CMS website.

Additional Changes

The following Ambulatory Payment Classification (APC) was added to the I/OCE, effective 04-01-10.

APC	APC Description	Status Indicator
01310	Pneumococcal vacc, 13 val im	K

The following APC(s) were added to the I/OCE, effective 07-01-10.

APC	APC Description	Status Indicator
09264	Tocilizumab injection	G
09265	Romidepsin injection	G
09266	Collagenase clostridium histo	G
09267	Injection, Wilate	G
09268	Capsaicin patch	G
09367	Endoform Dermal Template	G

The following APC had description changes, effective 07-01-10.

APC	Old Description	New Description
09262	Fludarabine phosphate, oral	Oral Fludarabine phosphate

The following new HCPCS/CPT code(s) were added to the I/OCE, effective 01-01-10.

HCPCS	Code Description	SI	APC	Edit	Active Date
C9800	Dermal filler inj px/suppl	T	00135	55	20100323
G0429	Dermal filler injection(s)	B	00000	62	20100323
Q2026	Radiesse injection	B	00000	62	20100323
Q2027	Sculptra injection	B	00000	62	20100323

The following new HCPCS/CPT code was added to the I/OCE, effective 04-01-10.

HCPCS	Code Description	SI	APC	Edit
G0428	Collagen Meniscus Implant	E	00000	9

The following new HCPCS/CPT code(s) were added to the I/OCE, effective 07-01-10.

HCPCS	Code Description	SI	APC	Edit
0223T	Acoustic/electr cardgrphy	S	00099	
0224T	Acstic/elec cardgrphy av/vv	S	00690	
0225T	Acstic/elec cardgrphy av+vv	S	00690	
0226T	Anosc high resol dx +-coll	X	00340	
0227T	Anosc high resol dx w/bx	T	00146	
0228T	US tfrml edrl inj crv/t 1lvl	T	00207	
0229T	US tfrml edrl inj crv/t +lvl	T	00206	
0230T	US tfrml edrl inj l/s 1lvl	T	00207	
0231T	US tfrml edrl inj l/s +lvl	T	00206	
0232T	Inj plsm img guid hvrst&prep	X	00340	
0233T	Skn age meas spctrscopy	A	00000	
90664	Flu vacc pandemic live nasal	E	00000	28
90666	Flu vacc pandemic no prsv im	E	00000	28
90667	Flu vacc pandemic adj im	E	00000	28
90668	Flu vacc pandemic split v im	E	00000	28
C9264	Tocilizumab injection	G	09264	55
C9265	Romidepsin injection	G	09265	55
C9266	Collagenase clostridium histo	G	09266	55
C9267	Injection, Wilate	G	09267	55
C9268	Capsaicin patch	G	09268	55
C9367	Endoform Dermal Template	G	09367	55
Q2025	Oral Fludarabine phosphate	G	09262	?

The following HCPCS/CPT code was deleted from the I/OCE, effective 07-01-10.

HCPCS	Code Description
C9262	Fludarabine phosphate, oral

The following code descriptions were changed, effective 07-01-10.

HCPCS	Old Description	New Description
K0669	Seat/back cus no sadmerc ver	Seat/back cus no dmepdac ver
K0899	Pow mobil dev no SADMERC	Pow mobil dev no dme pdac

The following code had an APC and/or SI and/or Edit change, effective 04-01-10.

HCPCS	Code Description	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90670	Pneumococcal vacc, 13 val im	00000	01310	E	K	9	N/A

The following codes were added to Edit 68 effective 01-01-10.

HCPCS	Edit#	ActivDate	TermDate
C9800	68	20100323	0
G0429	68	20100323	0
Q2026	68	20100323	0
Q2027	68	20100323	0

Additional Information

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

The official instruction (CR6967) issued to your Medicare MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R1982CP.pdf> on the CMS website.

JULY 2010 UPDATE OF THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6996 Revised
Related CR Release Date: May 28, 2010
Related CR Transmittal #: R128BP and R1980CP

Related Change Request (CR) #: 6996
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: This article was revised on June 7, 2010, to reflect a revised CR 6996 that was issued on June 4. The CR was revised to show a correct payment rate of \$25.61 for HCPCS code G9141 ((Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family))). The article was revised accordingly. In addition, the CR release date, transmittal number, and the web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the OPSS are affected.

What You Need to Know

This article is based on Change Request (CR) 6996 which describes changes to and billing instructions for various payment policies implemented in the July 2010 OPSS update. The July 2010 Integrated Outpatient Code Editor (I/OCE) and OPSS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 6996.

July 2010 revisions to I/OCE data files, instructions, and specifications are provided in CR 6967, July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2.” The MLN Matters® article related to CR 6967 is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM6967.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Background

Change Request (CR) 6996 updates Sections 20.4 and 20.5 of Chapter 6 of the Medicare Benefits Policy Manual to further clarify CMS policies requiring physician supervision of diagnostic and therapeutic services provided to hospital outpatients.

CMS updated Sections 20.4 and 20.5 to reflect changes in these policies that were implemented in the Calendar Year (CY) 2010 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System (OPPS/ASC) final rule with comment period [(74 FR 60588 through 60591; Hospital Outpatient Diagnostic Services); (74 FR 60578 through 60588); Hospital Outpatient Therapeutic Services)]. CR 6996 further clarifies CY 2010 CMS policies in response to additional questions and comments received since publication of that rule. Specifically, CR 6996 discusses:

- Discusses supervision of diagnostic tests by non-physician practitioners;
- Defines the term “immediately available”;
- Clarifies the credentials, knowledge, skills, ability, and privileges that the supervisory practitioner must possess in order to be qualified to perform a given service or procedure; and
- Clarifies what constitutes a therapeutic service in the hospital outpatient department, including observation.

These updates to Sections 20.4 and 20.5 of the Medicare Benefits Policy Manual are included as an attachment to CR 6996. The updates are summarized as follows:

- Physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives who operate within the scope of practice under State law may order and perform diagnostic tests, as discussed in 42 CFR 410.32(a)(2) and corresponding guidance in chapter 15, section 80 of this manual. However, this manual guidance and the long established regulation at 42 CFR 410.32(b)(1) also state that diagnostic x-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act. Some of these non-physician practitioners may perform diagnostic tests without supervision, see the regulation at 410.32(b)(2) and 42 CFR 410.32(b)(3). Thus, while physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives only require physician supervision included in any collaboration or supervision requirements particular to that type of practitioner when they personally perform a diagnostic test, these practitioners are not permitted to function as supervisory “physicians” for the purposes of other hospital staff performing diagnostic tests.
- Immediate availability requires the immediate physical presence of the physician. CMS has not specifically defined the word “immediate” in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away.
- The supervisory physician must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test.
- & The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure and, as appropriate to the supervisory physician and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory physician would

make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner. In summary, the supervisory physician must be clinically appropriate to supervise the service or procedure.

- & Direct supervision is the minimum standard for supervision of all Medicare hospital outpatient therapeutic services. Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. For services not furnished directly by a physician or nonphysician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate.

Note: CMS decided not to enforce the requirements for direct supervision of therapeutic services that are furnished to outpatients in critical access hospitals (CAHs) during calendar year 2010. For more information on this issue, see <http://www.cms.gov/HospitalOutpatientPPS/Downloads/WebNotice.pdf> on the CMS website.

In addition, CR 6996 makes the following OPSS changes:

1. Procedure to Device Edits for July 2010

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.gov/HospitalOutpatientPPS/> on the CMS website.

2. Category III CPT Codes

The American Medical Association (AMA) releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, CMS implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPSS final rule with comment period (70 FR 68567; see http://www.access.gpo.gov/su_docs/fedreg/a051110c.html on the Internet), CMS modified the process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPSS and were created in response to

applications for new technology services. Therefore, on July 1, 2010, CMS is implementing the OPPS 11 Category III CPT codes that the AMA released in January 2010 for implementation in July 2010. Of the 11 Category III CPT codes, 10 are separately payable under the hospital OPPS. The Category III CPT codes, status indicators (SI), and Ambulatory Payment Classifications (APC) are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2010 OPPS Update that is posted at

<http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS website. CPT code 0233T (skin advanced glycation end products (AGE) measurement by multi-wavelength fluorescent spectroscopy) will be paid under the Medicare Physician Fee Schedule, beginning July 1, 2010, when billed by OPPS providers.

Table 1--Category III CPT Codes Implemented as of July 1, 2010

HCPCS	Long Descriptor	SI	APC
0223T	Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report	S	0099
0224T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report	S	0690
0225T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report	S	0690
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	X	0340
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	T	0146
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	T	0207
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	T	0206
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	T	0207
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	T	0206
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	X	0340
0233T	Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy	A	NA

3. Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

Effective for claims with dates of service on and after March 23, 2010, coverage for dermal injections for the treatment of facial lipodystrophy syndrome (LDS) is considered

reasonable and necessary only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment. CMS will cover and pay separately for the dermal filler injection procedure and the dermal filler products that are approved by the Food and Drug Administration (FDA).

CMS has created four Level II HCPCS codes to describe the dermal filler injection procedure and the dermal filler products. Those codes are shown in Table 2 below. Under the hospital OPPS, CMS has assigned HCPCS code C9800 to APC 0135 with an SI of "T." Since HCPCS code C9800 describes both the injection procedure and the dermal filler items and supplies, CMS has assigned HCPCS codes G0429, Q2026, and Q2027 to SI "B" to indicate that these codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x or 13x.

Table 2—HCPCS Codes for Dermal Filler Injection Implemented as of July 1, 2010

HCPCS	Long Descriptor	SI	APC
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	T	0135
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA
Q2026	Injection, Radiesse, 0.1 ml	B	NA
Q2027	Injection, Sculptra, 0.1 ml	B	NA

4. Billing for Allogeneic Stem Cell Transplant Procedures

CR 6996 revises Section 231.11 of the Medicare Claims Processing Manual (Chapter 4) to clarify that charges for allogeneic stem cell acquisition services billed with revenue code 0819 (Other Organ Acquisition) should be reported on the same date of service as the allogeneic transplant procedure in order to be appropriately packaged for payment purposes. The revision to Section 231.11 of the Medicare Claims Processing Manual is included as an attachment to CR 6996.

5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2010

For CY 2010, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2010, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2010, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2010 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2010 release of the OPPS Pricer. The updated payment rates, effective July 1, 2010 will be included in the July 2010 update of the OPPS Addendum A and Addendum B, which will be posted at <http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2010

Six drugs and biologicals have been granted OPPS pass-through status effective July 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 3 below.

Table 3—Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/10
C9264*	Injection, tocilizumab, 1mg	9264	G
C9265*	Injection, romidepsin, 1 mg	9265	G
C9266*	Injection, collagenase clostridium histolyticum, 0.1 mg	9266	G
C9267*	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	9267	G
C9268*	Capsaicin, patch, 10cm2	9268	G
C9367*	Skin substitute, Endoform Dermal Template, per square centimeter	9367	G

NOTE: The HCPCS codes identified with an “*” indicate that these are new codes effective July 1, 2010.

c. New HCPCS Codes Effective for Certain Drugs and Biologicals

One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for July 2010. This code is listed in Table 4 below and replaces C9262. This code is effective for services furnished on or after July 1, 2010.

Table 4— New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/10
Q2025	Fludarabine phosphate, oral, 1 mg	9262	G

d. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

The payment rates for three HCPCS codes were incorrect in the April 2010 OPSS Pricer. The corrected payment rates are listed in Table 5 below and have been incorporated into the reissued Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Affected claims that were already processed/paid prior to the reissued Pricer, have been reprocessed (or are in the process of being reprocessed).

Table 5—Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9258	G	9258	Telavancin injection	\$2.12	\$0.42
C9262	G	9262	Fludarabine phosphate, oral	\$8.18	\$1.61
J1540	K	0923	Gamma globulin 9 CC inj	\$141.64	\$28.33

e. Adjustment to Status Indicator for HCPCS Code 90670 Effective April 1, 2010

Effective April 1, 2010, the status indicator for HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPSS; separate APC payment). For the remainder of CY 2010, HCPCS code 90670 will be separately paid and the price will be updated on a quarterly basis.

f. Category I H1N1 Vaccine CPT Codes

As stated in the October 2009 Update of the hospital OPSS that was published in CR 6626 (Transmittal 1803, August 28, 2009; see <http://www.cms.gov/MLN Matters Articles/downloads/MM6626.pdf> on the CMS website), CMS created two Level II HCPCS codes to describe the H1N1 vaccine itself and the H1N1 vaccine administration. Specifically, G9141 (Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family))

and G9142 (Influenza a (h1n1) vaccine, any route of administration) were made effective September 1, 2009. Under the OPSS, HCPCS code G9142 is assigned to status indicator “E” indicating that payment is not made by Medicare when this code is submitted on an outpatient bill type because the H1N1 vaccine is supplied at no cost to providers. However, payment will be made to a provider for the administration of the H1N1 vaccine when reported under HCPCS code G9141, even if the vaccine is supplied at no cost to the provider. HCPCS code G9141 is assigned to APC 0350 (Administration of Flu and PPV Vaccine) with a status indicator of “S” and a payment rate of \$25.61 for CY 2010. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPSS and non OPSS providers). Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

In January 2010, the CPT Editorial Panel, through the AMA website, released four new H1N1 vaccine CPT codes for implementation on July 1, 2010. The four new H1N1 vaccine codes are: 90664, 90666, 90667, and 90668 (see Table 6 for the code descriptors). CMS notes that CPT code 90663 was made effective September 28, 2009, and was assigned to status indicator “E” under the OPSS since its effective date. Because two existing H1N1 G-codes appropriately describe the vaccine itself and the administration, Medicare will only recognize the G-codes. Under the hospital OPSS, providers must report the H1N1 vaccine itself by reporting G9142 and G9141 for the H1N1 vaccine administration. Table 6 provides a list of H1N1 vaccine and H1N1 vaccine administration HCPCS codes, status indicators, APCs, and payment rates as of July 1, 2010 under the hospital OPSS.

Table 6—H1N1 Vaccine and H1N1 Vaccine Administration HCPCS Codes as of July 1, 2010

	HCPCS	Long Descriptor	SI	APC	Payment Rate
H1N1 Vaccine HCPCS Codes	G9142	Influenza a (h1n1) vaccine, any route of administration	E	NA	NA
	90663	Influenza virus vaccine, pandemic formulation, H1N1	E	NA	NA
	90664	Influenza Influenza virus vaccine, pandemic formulation, live, for intranasal use	E	NA	NA
	90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	E	NA	NA
	90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	E	NA	NA
	90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	E	NA	NA

	HCPCS	Long Descriptor	SI	APC	Payment Rate
H1N1 Vaccine Administration HCPCS Codes	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)	S	0350	\$25.61
	90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed	E	NA	NA

g. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPSS payment for the biological is packaged into the payment for the associated procedure.

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

h. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

For example,

- If the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1; and
- If the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4.

Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, the hospital should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in the Medicare Claims Processing Manual (Chapter 17, Section 40; see, <http://www.cms.gov/manuals/downloads/clm104c17.pdf> on the CMS website) CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

i. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPDS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and CMS expects that the majority of hospitals will not encounter this situation.

6. Information regarding the Core-Based Statistical Area (CBSA) and Wage Indexes in effect for CY 2010

The Affordable Care Act (ACA); Sections 3137(a) and 10317 of Pub. L. 111-148; (see http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf on the Internet) revised the wage indexes that are in effect for FY 2010. As a result of these changes, instructions were issued to contractors in a separate CR, regarding the revised wage indexes in effect for FY 2010. The OPSS adopts the post reclassification fiscal year wage index in effect for the inpatient prospective payment system (IPPS) on a calendar year basis. Therefore, CMS adopted the reclassified wage indexes that began for IPPS payment on April 1, 2010, for hospital outpatient payment under the OPSS beginning July 1, 2010, to align the mid-year change in post-reclassification wages for some CBSAs with the OPSS calendar year payment period. The OPSS also adopts section 508 geographic reclassifications on a fiscal year basis. The ACA extended section 508 reclassification wage indexes through September 30, 2010. Similar to CMS' treatment of section 508 reclassifications as previously extended under 124 of Pub. L. 110- 275 (MIPPA), hospitals with section 508 reclassifications will revert to their home area wage index, with out-migration adjustment if applicable, from October 1, 2010, to December 31, 2010. As CMS did for CY 2009, CMS is also beginning reclassification wage indexes for certain special exception hospitals on January 1, 2010, and extending them through December 31, 2010. Please note that the wage indexes included in the July 1, 2010 OPSS Pricer reflect the revised post-reclassification wage index values implemented for the IPPS on April 1, 2010. Contractors shall maintain the current CBSA value assigned to all OPSS hospitals, including those with non section 508 wage index reclassifications that have been approved by the Medicare Geographic Classification Review Board (MGRB).

7. Coverage Determinations

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

Additional Information

The official instruction, CR6996, was issued to your FI, RHHI, and A/B MAC in two transmittals. One transmittal modifies the Medicare Claims Processing Manual and it is available at <http://www.cms.gov/Transmittals/downloads/R1980CP.pdf> on the CMS website. The other modifies the Medicare Benefit Policy Manual and it is at <http://www.cms.gov/Transmittals/downloads/R128BP.pdf> on the CMS website.

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

**JULY UPDATE TO THE 2010 MEDICARE PHYSICIAN FEE SCHEDULE
DATABASE (MPFSDB)
~CMS MLN Matters~**

MLN Matters   Number: MM6974
Related CR Release Date: June 25, 2010
Related CR Transmittal #: R1992CP

Related Change Request (CR) #: 6974
Effective Date: January 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 6974, which amends payment files that were issued to Medicare contractors based on the 2010 Medicare Physician Fee Schedule (MPFS) Final Rule. Be sure your billing staff is aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2010 Medicare Physician Fee Schedule (MPFS) Final Rule. Change Request (CR) 6974 amends those payment files. CR 6974 provides corrections, effective for dates of service on or after January 1, 2010, to those files. These changes include the following:

CPT/HCPCS Code	ACTION
36148	Multiple Procedure Indicator = 0
74261	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
74261 - TC	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
74262	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
74262 - TC	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
97026	Procedure Status = R

Pharmacogenomic Testing for Warfarin Response

Healthcare Common Procedure Coding System (HCPCS) code G9143 was implemented with the 2010 HCPCS file with an effective date of August 3, 2009. Currently, Medicare contractors have a 2010 MPFSDB record but not a 2009 MPFSDB record. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after August 3, 2009.

CPT Code 90470

CPT code 90470 became effective on September 28, 2009. However, due to an off cycle effective date it was not included on the MPFSDB for 2009. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after September 28, 2009.

Screening for the Human Immunodeficiency Virus (HIV) Infection

On December 8, 2009, CMS issued a non-coverage decision (Transmittal 118, Change Request 6786, dated March 23, 2010) on screening for HIV infection. Medicare contractors were instructed to manually add HCPCS codes G0432, G0433 and G0435 to the procedure code file and MPFSDB effective for dates of service on or after December 8, 2009.

Outpatient Intravenous Insulin Treatment (OIVIT)

On December 23, 2009, CMS issued a non-coverage decision (Transmittal 114, Change Request 6775, dated February 22, 2010) on the use of OIVIT. Contractors were instructed to manually add HCPCS code G9147 to the procedure code file and MPFSDB effective for dates of service on or after December 23, 2009.

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS codes G0429, Q2026, and Q2027 on the procedure code file and the MPFSDB. HCPCS codes G0429 (Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)), Q2026 (Injection, Radiesse, 0.1ml) and Q2027 (Injection, Sculptra, 0.1ml) are effective for dates of service on or after March 23, 2010.

Collagen Meniscus Implant

In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS code G0428 (Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) on the procedure code file and the MPFSDB. HCPCS code G0428 is effective for dates of service on or after May 25, 2010.

Other Changes

In addition to the above, Attachment 1 of CR6974 contains numerous adjustments of the MPFSDB for various CPT/HCPCS codes and associated indicators. This attachment to CR 6974 can be viewed at <http://www.cms.gov/Transmittals/downloads/R1992cp.pdf> on the CMS website.

Additional Information

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that are affected by these changes. However, contractors will adjust such claims that you bring to their attention.

The official instruction, CR 6974, issued to your carrier, FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1992cp.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI, or A/B MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

MEDICALLY UNLIKELY EDITS (MUES)
~CMS Transmittal~

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare Medicaid Services (CMS)
Transmittal 652	Date: March 17, 2010
	Change Request 6712

Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs, and (2) clarifies the name of files for the final DME list of MUEs, and provides the denial reason code to be used for MUE denials.

SUBJECT: Medically Unlikely Edits (MUEs)

I. SUMMARY OF CHANGES: CMS developed the MUE program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. Note that the MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE.

This CR provides updates and clarifications to MUE requirements established in 2006.

NEW / REVISED MATERIAL

EFFECTIVE DATE: APRIL 1, 2010

IMPLEMENTATION DATE: APRIL 5, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:**SECTION A: For Fiscal Intermediaries and Carriers:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:**One-Time Notification**

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 652	Date: March 17, 2010	Change Request 6712
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Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs, and (2) clarifies the name of files for the final DME list of MUEs, and provides the denial reason code to be used for MUE denials.

SUBJECT: Medically Unlikely Edits (MUEs)

EFFECTIVE DATE: APRIL 1, 2010

IMPLEMENTATION DATE: APRIL 5, 2010

I. GENERAL INFORMATION:

A. Background: CMS developed the MUE program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. Note that the MUE program provides a method to report medically likely UOS in excess of an MUE.

Further, all CMS claims processing contractors (including contractors using the Fiscal Intermediary Shared System (FISS)) shall adjudicate MUEs against each line of a claim rather than the entire claim. Thus, if a HCPCS/CPT code is changed on more than one line of a claim by using CPT modifiers, the claims processing system separately adjudicates each line with that code against the MUE.

In addition, fiscal intermediaries (FIs), carriers and Medicare Administrative Contractors (MACs) processing claims shall deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed.

Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. CPT modifiers such as 76 (repeat procedure by same physician), 77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), 91 (repeat clinical diagnostic laboratory test), and 59 (distinct procedural service), will accomplish this purpose. Providers/suppliers should use Modifier 59 only if no other modifier describes the service.

On or about October 1, 2008, CMS announced that it would publish at the start of each calendar quarter the majority of active MUEs and post them on the MUE web page at ["http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage."](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage)

Note that, at the onset of the MUE program, all MUE values were confidential, and for use only by CMS and CMS contractors. Since October 1, 2008, CMS has published most MUE values at the start of each calendar quarter. However, some MUE values are not published and continue to be confidential information for use by CMS and CMS contractors only. The confidential MUE values shall not be shared with providers/suppliers or other parties outside the CMS contractor's organization. The files referenced in the business requirements of this CR contain both published and unpublished MUE values. In the MUE files each HCPCS code has an associated "Publication Indicator". A Publication Indicator of "0" indicates that the MUE value for that code is confidential, is not in the CMS official publication of the MUE values, and should not be shared with providers/suppliers or other parties outside the CMS contractor's organization. A Publication Indicator of "1" indicates that the MUE value for that code is published and may be shared with other parties.

The full set of MUEs is available for the CMS contractors only via the Baltimore data center (BDC). A test file will be available about 2 months before the beginning of each quarter, and the final file will be available about 6 weeks before the beginning of each quarter. Note that MUE file updates are a full replacement. The MUE adds, deletes, and changes lists will be available about 5 weeks before the beginning of each quarter.

This CR provides updates and clarifications to MUE requirements established in 2006.

B. Policy: The NCCI contractor produces a table of MUEs. The table contains ASCII text and consists of six columns (Refer to Appendix 1 – Tabular Presentation of the Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare Carrier System (MCS), one for contractors using the VIPS Medicare System (VMS) system, and one for the contractors using the FISS system.

Contractors shall apply MUEs to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, PIM, chapter 3, section 3.5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

The CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Since claim lines are denied, denials may be appealed.

Appeals shall be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier shall not issue an Advance Beneficiary Notice of Noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

The denied units of service shall be a provider/supplier liability.

The CMS will distribute the MUEs as a separate file for each shared system when the quarterly NCCI edits are distributed.

II. BUSINESS REQUIREMENTS

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CBF	
6712.1	The shared systems maintainers shall develop a line level edit to deny the entire line on the claim when the units of service are in excess of the MUE value. FISS is not checked because FISS provides the capability for contractors to return the claim to the provider (RTP) or deny the line item that contain units that exceed the MUE.	X	X		X						

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.										
6712.1.1	Since contractors that use the FISS have the ability to either return the claim to the provider or deny the claim line, those contractors shall deny the line item.	X		X							
6712.1.2	Currently Part A contractors RTP claims that hit the MUE edit (reason code 31715). BR 6712.1, will deny the lines of service based on MUE table and the claim dates of service effective 040110. The current MUE edit (reason code 31715) shall have a term date of March 31, 2010 to stop editing when CR 6712 becomes effective.						X				
6712.1.2.1	MACs shall change the status and location of reason code 31715 from T (RTP claims) to a D (deny claims) for claims processed on and after April 1, 2010.	X		X							
6712.1.3	The shared system maintainers shall design the module to accept updates to MUEs using the format in Appendix 1.		X					X	X		
6712.1.4	The shared system maintainers shall expand the size of the maximum units (see Appendix 1) from two (size in the current MUE module) to five.		X					X	X		
6712.2	The shared system maintainer shall allow for the retention of the five most recent unit values for each MUE.		X					X	X		
6712.2.1	The shared system maintainer shall allow for all five values to be active at the same time.		X					X	X		
6712.2.2	The MUE values shall be distinguishable by the begin and end dates for each value. VMS is not checked because the VMS system already meets this requirement.						X	X			
6712.3	The shared system module shall calculate units of service for a service provided over a period of time greater than 1 day as a per day number rounded to the nearest whole number. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.						X				
6712.3.1	For each day in the period, the shared systems shall deny the entire claim line when the units of service for the claim line is greater than the units of service stated in	X	X		X						

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the file. This BR does not apply to the FISS system because the FISS system only allows one date of service per line. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.										
6712.3.1.1	Since contractors that use the FISS have the ability to either return the claim to the provider or deny the claim line, those contractors shall deny the line item.	X		X							
6712.4	The shared system module shall apply MUEs after all other edits and audits have completed and before the claim is sent to CWF. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.						X				
6712.5	Data centers (Enterprise Data Centers [EDCs] or contractor data centers [CDCs]) shall install the MUE shared system module developed for this CR in time for the implementation date of this CR.	X	X	X	X						EDCs AND CDCs
6712.6	Contractors shall insure that the MUE shared system module developed in business requirement 6712.1, begins to operate in time so that the entire claims line is denied when the units of service are in excess of the MUE value.	X	X	X	X						
6712.7	Medicare contractors shall afford physicians, suppliers, facilities and beneficiaries appeal rights under the Medicare claims appeal process (See Pub 100-4, CPM, chapter 29.)	X	X	X	X						
6712.8	Medicare contractors shall refer any request to modify the MUE value for a specific code to: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907, Carmel, IN 46082-0907	X	X	X	X						
6712.8.1	Upon the review of appropriate reconsideration documents provided by a national organization/provider, CMS' data and other CMS resources, the NCCI/MUE Contractor will consult with the CMS MUE Workgroup and a decision shall be made by CMS whether or not to modify the MUE.										NCCI/ MUE Contractor and CMS/MUE Work-group
6712.9	Beginning on the implementation date for	X	X	X	X	X	X	X			

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	this CR, Medicare contractors shall apply MUEs to claims and adjustments with dates of service on or after the beginning effective date of the MUE and on or before the ending effective date of the MUE. VMS is not checked because the VMS system already meets this requirement.										
6712.9.1	Shared system maintainers shall continue to insure that MUEs are applied based on date of service. CMS has noted that all shared systems maintainer currently provide this capability.		X					X	X		
6712.10	Contractors shall begin denying the entire claim line when the units of service on that line are in excess of the MUE value and assign MSN message # 15.6, ANSI reason code 151 , group code CO (contractual obligation), and remark codes # N362 and MA01 to claims that fail the MUEs.	X	X	X	X	X					
6712.11	Medicare contractors shall classify MUEs as PIMR activity code 210011 in PIMR and activity code 11205 in CAFM.	X	X	X	X	X					
6712.12	The filenames to access for the carriers and the FIs are: Test File: MU00.@BF12372.MUE.CARR.TEST02.V* MU00.@BF12372.MUE.FI.TEST02.V* MU00.@BF12372.MUE.DME.TEST02.V* Final File: MU00.@BF12372.MUE.CARR.FINAL01.V* MU00.@BF12372.MUE.FI.FINAL01.V* MU00.@BF12372.MUE.DME.FINAL01.V* Where "*" indicates current generation number for all files except MU00.@BF12372.MUE.DME.FINAL01.* . For MU00.@BF12372.MUE.DME.FINAL01.V* , "*" indicates version number – MU00.@BF12372.MUE.DME.FINAL01.V* are flat files.	X	X	X	X	X		X	X	BDC, EDC, and CDCs	
6712.13	Contractors shall classify MUE denials as coding denials, not as medical necessity denials.	X	X	X	X	X					
6712.13.1	A provider shall not use an Advanced Beneficiary Notice (ABN) to seek payment from a patient for UOS denied due to an	X	X	X	X	X					Providers

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MUE.										
6712.13.2	The MUE denials shall have “provider liability.”	X	X	X	X						
6712.13.3	The MUE denials cannot be waived nor subject to an ABN.	X	X	X	X						
6712.14	Contractors may process claim service lines that exceed MUE limits and also contain a 55 modifier in a manner such that the MUE audit will not systematically deny the service line.	X			X	X		X			
6712.14.1	At contractor discretion, contractors may determine that these services must be suspended for contractor review and input.	X			X	X		X			
6712.15	Contractors shall refer providers to the website: “ http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage ” for current information on the MUE program.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
6712.16	Contractors shall post this entire instruction, or a direct link to this instruction, on their websites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the Contractors next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X			X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
None	

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s):

John Stewart (410) 786-1189, John.Stewart@CMS.HHS.GOV,

Val Allen (410) 786-7443, valeria.allen@cms.hhs.gov

Post-Implementation contact(s):

John Stewart, (410) 786-1189, John.Stewart@CMS.HHS.GOV

Val Allen (410), 786-7443, valeria.allen@cms.hhs.gov

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

**APPENDIX 1
TABULAR PRESENTATION OF THE FORMAT FOR THE MUE TRANSMISSION**

Below are layouts for each of the shared systems. A description of each column on the layouts is provided below. Note that all layouts are the same.

The first column contains HCPCS codes (5 positions). The second column of the first format chart contains the maximum units of service A/B MACs and Medicare fiscal intermediaries shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The second column of the second format chart contains the maximum units of service A/B MACs and Medicare carriers shall allow per claim line per day for the HCPCS code in

column one (5 positions with no decimal places). The second column of the third format chart contains the maximum units of service DME MACs shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The third column is the Corresponding Language Example Identification (CLEID) Number (12 positions including a decimal point). The CLEID information is for reference only. The fourth column states the beginning effective date for the edit (7 positions in YYYYDDD format), and the fifth column states the ending effective date of the edit (7 positions in YYYYDDD format). For example, April 1, 2007, is recorded as 2007091 meaning the 91st day of 2007. The fifth column will remain blank until an ending effective date is determined. The last column indicates whether CMS will publish the MUE units on the CMS website:

["http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage."](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage) A "1" indicates that CMS will publish the MUE units on the CMS website.

FORMAT FOR CLAIMS PROCESSED USING THE FISS SYSTEM

HCPCS CODE	MAXIMUM MAC/FI UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES

A = ALPHANUMERIC CHARACTER

X = NUMERIC CHARACTER

YYYYXXX = JULIAN DATE

PUBLICATION INDICATOR

NO = CMS WILL NOT PUBLISH -- DO NOT SHARE

YES = CMS WILL PUBLISH -- OK TO SHARE

FORMAT FOR CLAIMS PROCESSED USING THE MCS SYSTEM

HCPCS CODE	MAXIMUM MAC/CARRIER UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES

A = ALPHANUMERIC CHARACTER

X = NUMERIC CHARACTER

YYYYXXX = JULIAN DATE

PUBLICATON INDICATOR

NO = CMS WILL NOT PUBLISH -- DO NOT SHARE

YES = CMS WILL PUBLISH -- OK TO SHARE

FORMAT FOR CLAIMS PROCESSED USING THE VMS SYSTEM

HCPCS CODE	MAXIMUM DME MAC UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES

A = ALPHANUMERIC CHARACTER

X = NUMERIC CHARACTER

YYYYXXX = JULIAN DATE

PUBLICATON INDICATOR

NO = CMS WILL NOT PUBLISH -- DO NOT SHARE

YES = CMS WILL PUBLISH -- OK TO SHARE

MEDICARE CONTRACTOR ANNUAL UPDATE OF THE INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION, CLINICAL MODIFICATION (ICD-9-CM)

~ Revised CMS MLN Matters ~

MLN Matters Number: MM7006 Revised
Related CR Release Date: August 4, 2010
Related CR Transmittal #: R2017CP

Related Change Request (CR) #: 7006
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Note: This article was revised on August 4, 2010, to reflect the revised CR 7006, which was revised on August 4. In this article, the CR release date and Transmittal number (see above) were changed and the web address for accessing CR 7006 was also changed. All other information is the same.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims. However, an ICD-9-CM code is not required for ambulance supplier claims.

Additional Information

For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at <http://www.cms.gov/Transmittals/downloads/R2017CP.pdf> on the CMS website.

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

**OCTOBER QUARTERLY UPDATE TO 2010 ANNUAL UPDATE OF
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)
CODES USED FOR SKILLED NURSING FACILITY (SNF)
CONSOLIDATED BILLING (CB) ENFORCEMENT
~CMS MLN Matters~**

MLN Matters® Number: MM7002
Related CR Release Date: June 18, 2010
Related CR Transmittal #: R1989CP

Related Change Request (CR) #: 7002
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, skilled nursing facilities, suppliers, and other providers submitting claims to Medicare contractors (fiscal intermediaries (FI), or Part A/B Medicare Administrative Contractors (A/B MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 7002, from which this article is taken, provides the October quarterly update to the 2010 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) consolidated billing (CB). You should make sure your billing staffs are aware of the HCPCS code changes (effective October 1, 2010) that are provided in the Background section, below.

Background

Section 1888 of the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) codifies the SNF Prospective Payment System (PPS) and CB; and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS.

The SNF CB file reflects new codes that have been developed, and those that have been discontinued, for 2010, and any additions and deletions to categories of services excluded from CB. Please note that these new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined; nor will any additional services be added by these routine updates. Other regulatory changes beyond code list updates will be noted when, and if, they occur.

Medicare will pay SNF claims submitted to Medicare contractors for HCPCS codes **only when they are included** in SNF CB (in other words, do not appear on the **exclusion** list)

Conversely, services **excluded** from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when in a SNF stay. Regardless, in order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. Further, SNF CB applies to non-therapy services, only when they are furnished to a SNF resident during a covered Part A stay; however, it applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

The Current Procedural Terminology (CPT) codes in the following table will be terminated from the annotated Major Categories in the FI/A/B MAC file effective December 31, 2009:

Table 1
CPT Codes Terminated in the FI/A/B MAC File, Effective December 31, 2009*

Major Category I.C – Magnetic Resonance Imaging (MRI)	
CPT Code	Long Description
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; 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
Major Category I.E – Angiography, Lymphatic, Venous and Related Procedures	
CPT Code	Long Description
75790	Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation

The CPT codes in the following table will be added to the annotated Major Categories in the FI/A/B MAC file effective December 31, 2009:

Table 2
CPT Codes Added to the FI/A/B MAC File, Effective January 1, 2010*

Major Category I.C – Magnetic Resonance Imaging (MRI)	
CPT Code	Long Description
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)

Major Category I.C – Magnetic Resonance Imaging (MRI)	
CPT Code	Long Description
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

Major Category I.E – Angiography, Lymphatic, Venous and Related Procedures	
CPT Code	Long Description
75791	Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis).

*Codes added or terminated with this update are available at http://www.cms.gov/SNFConsolidatedBilling/72_2010Update.asp#TopOfPage on the CMS website.

Finally, for Indian Health Service (IHS) providers, your FI or MAC will bypass 13x bill types containing emergency care Evaluation & Management (E&M) codes 99281, 99282, 99283, 99284, 99285 (effective January 1, 2010) using the same bypass logic as currently done when a revenue code 045x is present on an outpatient hospital claim (this includes the usage of modifier ‘ET’ for emergency services that span multiple service dates).

Additional Information

You can find the official instruction, CR 7002, issued to your FI, carrier, or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R1989CP.pdf> on the CMS website.

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

QUARTERLY HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODE CHANGES – JULY 2010 UPDATE
~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6809 Revised
Related CR Release Date: May 21, 2010

Related Change Request (CR) #: 6809
Effective Date: July 1, 2010 unless otherwise specified
Implementation Date: July 6, 2010

Related CR Transmittal #: R1972CP

Note: This article was revised on May 27, 2010, to correct the long description for HCPCS Code Q2025 on page 2. The description was corrected to show 1mg. Also, reference to code WW141 was deleted. All other information is the same.

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME 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) 6809 which provides the Quarterly Healthcare Common Procedure Coding System (HCPCS) Code changes for the July 2010 Update. Be sure your billing staff know of these HCPCS code changes as noted below.

Background

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 6809 describes the process for updating these specific HCPCS codes.

Effective for claims with dates of service on or after July 1, 2010, the following HCPCS code will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2025	Oral fludarabine phosphate	Fludarabine phosphate, oral, 1mg	E

Note that suppliers are currently instructed to bill oral anti-cancer drugs to the DME MACs using the appropriate National Drug Code (NDC).

In addition, the Centers for Medicare & Medicaid Services (CMS) recently concluded that Dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Consequently, effective for claims with dates of service on or after March 23, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2026	Radiesse injection	Injection, Radiesse, 0.1ml	E
Q2027	Sculptra Injection	Injection, Sculptra, 0.1ml	E

Additional Information

Medicare contractors will not search their files to reprocess claims already processed, but will adjust such claims that you bring to their attention. The official instruction, CR 6809, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1972CP.pdf> on the CMS website.

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

**REVISED INSTRUCTIONS FOR REPORTING ASSESSMENT DATES
UNDER THE INPATIENT REHABILITATION FACILITY (IRF),
SKILLED NURSING FACILITY (SNF), AND SWING BED (SB)
PROSPECTIVE PAYMENT SYSTEMS (PPSS)**

~CMS MLN Matters~

MLN Matters® Number: MM7019
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R2011CP

Related Change Request (CR) #: 7019
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This article is for Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF), and Swing Bed (SB) providers paid under the respective Prospective Payment Systems (PPSs) for these providers. Facilities submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MAC)) for services paid under these PPSs are affected.

Provider Action Needed

This article, based on Change Request (CR) 7019, informs you that the assessment date data element has been removed from the new version of the 837I electronic format. Therefore, the Centers for Medicare & Medicaid Services (CMS) has revised the billing instruction to now require an occurrence code 50, for reporting assessment dates for IRF, SNF, and SB PPS providers, effective for dates of service on or after January 1, 2011. *Occurrence Code 50: Assessment Date* is defined as "Code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). (For IRFs, this is the date assessment data was transmitted to the CMS National Assessment Collection Database)." Please ensure that your billing staffs are aware of this change.

Background

Current Medicare instruction requires IRF and SNF PPS providers to report assessment dates in form locator 45, Service Date, of the UB-04 form or loop 2400, Date and Time Period (DTP) Assessment Date field, in the current 4010A1 837I electronic version. The DTP Assessment Date is removed from the new 837I electronic version. Because of the removal of this field, you will no longer be able to report assessment dates in the service date fields.

For IRF PPS, IRFs will begin using occurrence code 50 to report the date on which assessment data was transmitted to the CMS National Assessment Collection Database. Providers should no longer report this date in the service date field on the UB-04 and the 837I electronic version for dates of service on or after January 1, 2011. Occurrence code 50 must be reported on all IRF PPS 11x bill types for dates of service on or after January 1, 2011. Medicare will return such claims as unprocessed if you fail to include occurrence code 50.

Note: For IRFs, for a revenue code 0024 line containing case mix grouper (CMG) A9999, instead of inputting the transmission date of the IRF-Patient Assessment Instrument in the service date field (as is required on fee-for-service claims), input the discharge date as a default for these informational only claims. As of January 1, 2011, use occurrence code 50 to report this default discharge date, instead of using the service date field.

For service dates on or after January 1, 2011, SNF and SB PPS providers will append an occurrence code 50 with the Assessment Reference Date (ARD) for each Health Insurance Prospective Payment System Code (HIPPS) reported on the claim. Please note that HIPPS code AAxx (where 'xx' is varying digits) does not need an accompanying occurrence code 50. SNF providers must ensure that each HIPPS code reported on the claim is billed in the order in which that level of care is received for the month.

SNF and SB PPS providers, therefore, must include occurrence code 50 for each revenue code 0022 on your 21x and 18x bill types, except where the HIPPS code reported with the 0022 revenue code is AAxx. Medicare will return such claims as unprocessed if you do not include occurrence code 50. **Note:** Only one occurrence code 50 needs to be reported for 2 (two) HIPPS code lines that both end in the same two digits for the following HIPPS: xxx05, xxx06, xxx12, xxx13, xxx14, xxx15, xxx16, xxx17, xxx24, xxx25, xxx26, xxx34, xxx35, xxx36, xxx44, xxx45, xxx46, xxx54, xxx55, and xxx56, where "xxx" is varying digits.

Additional Information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2011CP.pdf> on the CMS website.

TIMELY CLAIMS FILING: ADDITIONAL INSTRUCTIONS

~CMS MLN Matters~

MLN Matters® Number: MM7080
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R734OTN

Related Change Request (CR) #: 7080
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7080 to expand the Medicare Fee-for-Service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS

reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

Background

CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended length of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the claim's "Through" date rather than the "From" date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the "From" date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claims processing contractors in their determination of timely filed claims. Therefore, the "From" date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the "From" date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key Points of CR 7080:

- For **institutional claims** that include span dates of service (i.e., a "From" and "Through" date span on the claim), the **"Through" date on the claim will be used to determine the date of service for claims filing timeliness.**
- For **professional claims (CMS-1500 Form and 837P)** submitted by physicians and other suppliers that include span dates of service, the line item **"From" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).**
- & **BE AWARE:** If a line item "From" date is not timely, but the "To" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.
- & Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional Information

Remember CR6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-ACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline; and
- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

You can find the official instruction, CR7080, issued to your carrier, FI, A/B MAC, or RHHI by visiting <http://www.cms.gov/Transmittals/downloads/R734OTN.pdf> on the CMS website.

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

To review MM6960, *Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months*, you may go to <http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf> on the CMS website.

Coverage – General**CARDIAC REHABILITATION AND INTENSIVE CARDIAC
REHABILITATION**
~CMS MLN Matters~

MLN Matters® Number: MM6850
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R1974CP, R126BP, R339PI,
and R170FM

Related Change Request (CR) #: 6850
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, and Part A/B Medicare Administrative Contractors (A/B MAC)) for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) program services provided to Medicare beneficiaries.

What You Need to Know

CR 6850, from which this article is taken, announces that, effective January 1, 2010, Medicare Part B pays for CR and ICR programs, and related items and services if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered, and the physician administering the program. Please see the Background section, below, for details.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for CR and ICR programs. The Centers for Medicare & Medicaid Services (CMS) implemented the MIPPA CR and ICR statutory coverage provisions through rule making, in the calendar year (CY) 2010 Physician Fee Schedule (PFS), by adding section 410.49 (Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage) to the Public Health Code of Federal Regulations (42 CFR).

The regulation at 42 CFR 410.49 includes all coverage provisions for CR and ICR items and services, identifies definitions, covered indications, settings, physician supervision requirements, and physician standards, required CR and ICR components, limitations to the number of sessions covered, and the period of time over which the sessions may be covered.

On October 30, 2009, the CY 2010 PFS Final Rule with Comment was finalized and put on display and is available at <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf> on the Internet. The Final Rule was published in the *Federal Register* on November 25, 2009, and is available on pages 62004-62005.

ICR services means a physician-supervised program that furnishes the same items/services under the same conditions as a CR program but must also demonstrate through peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements that are described in 42 CFR 410.49(c).

CR 6850 provides specific criteria for CR/ICR programs, outlined as follows:

CR/ICR Program Beneficiary Coverage Requirements (effective January 1, 2010)

Medicare Part B covers CR and ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
- A heart or heart-lung transplant; or,
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).

CR/ICR Program Component Requirements:

Covered CR and ICR programs must include the following components:

- **& Physician-prescribed exercise** - This physical activity includes aerobic exercise combined with other types of exercise (i.e., strengthening, stretching) as determined to be appropriate for individual patients by a physician each day CR/ICR items/services are furnished.
- **& Cardiac risk factor modification** - This includes education, counseling, and behavioral intervention, tailored to the patients' individual needs.
- **& Psychosocial assessment** - This assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation. It should include: (1) an assessment of those aspects of the individual's family and home situation that affects the individual's rehabilitation treatment, and, (2) a psychosocial evaluation of the individual's response to, and rate of progress under, the treatment plan.
- **& Outcomes assessment** - These should include: (i) minimally, assessments from the commencement and conclusion of CR/ICR, based on patient-centered outcomes which must be measured by the physician immediately at the beginning and end of the program, and, (ii) objective clinical measures of the effectiveness of the CR/ICR program for the individual patient, including exercise performance and self-reported measures of exertion and behavior.
- **& An individualized treatment plan** - This plan should be written and tailored to each individual patient and include (i) a description of the individual's diagnosis; (ii) the type, amount, frequency, and duration of the CR/ICR items/services furnished; and (iii) the goals set for the individual under the plan. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Frequency Limitations:

CR sessions are limited to a maximum of 2 one-hour sessions per day (up to 36 sessions, over a period of up to 36 weeks), with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Social Security Act.

ICR sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

CR/ICR Program Setting Requirements:

CR/ICR services must be furnished in a physician's office or a hospital outpatient setting (for ICR, the hospital outpatient setting must provide ICR using an approved ICR program). All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items/services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26, and for hospital outpatient services as specified at 42 CFR 410.27.

CR/ICR Program Physician Requirements:

Physicians responsible for CR/ICR programs are identified as medical directors who oversee or supervise the CR/ICR program at a particular site. The medical director, in consultation with staff, is involved in directing the progress of individuals in the program. The medical director, as well as physicians acting as the supervising physician, must possess all of the following: (1) expertise in the management of individuals with cardiac pathophysiology, (2) cardiopulmonary training in basic life support or advanced cardiac life support, and (3) license to practice medicine in the state in which the CR/ICR program is offered. Direct physician supervision may be provided by a supervising physician or the medical director.

ICR Program Approval Requirements:

All prospective ICR programs must be approved by CMS through the NCD process. To be approved, an ICR program must demonstrate through peer-reviewed, published research that it:

- Accomplished one or more of the following for its patients: (i) positively affected the progression of coronary heart disease, (ii) reduced the need for coronary bypass surgery, or, (iii) reduced the need for percutaneous coronary interventions; and,
- & Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services: (i) low density lipoprotein, (ii) triglycerides, (iii) body mass index, (iv) systolic blood pressure, (v) diastolic blood pressure, and, (vi) the need for cholesterol, blood pressure, and diabetes medications.

Once an ICR program is approved through the NCD process, all prospective ICR sites that want to furnish ICR items/services via the approved program must enroll with their local Medicare contractor to become an ICR program supplier using the designated forms at 42 CFR 424.510, and report specialty code 31 (single or multispecialty group practice) in order to be identified as an enrolled ICR supplier.

Note: For purposes of appealing an adverse determination concerning site approval, an ICR site is considered a supplier (or prospective supplier) as defined in 42 CFR 498.2.

A list of approved ICR programs, identified through the NCD process, will be posted to the CMS website and listed in the *Federal Register*.

Claims Processing Requirements

The following requirements all pertain to claims for CR and /or ICR services with dates of service on and after January 1, 2010.

Your carrier or MAC will pay for *professional* claims containing Healthcare Common Procedure Coding System (HCPCS) codes 93797 (Physician services for outpatient cardiac rehabilitation; without continuous electrocardiographic [ECG] monitoring [per session]), 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring [per session]), G0422 (Intensive Cardiac Rehabilitation; With or Without continuous ECG monitoring, With Exercise, Per Session), and G0423 (Intensive Cardiac Rehabilitation; With or Without continuous ECG monitoring, Without Exercise, Per Session) only when billed with place of service (POS) codes 11 (services provided in a physician's office) or 22 (services provided in a hospital outpatient setting).

They will deny all professional claims for CR/ICR services containing any other POS codes, using:

- Remittance Advice Remark Code (RARC) N428 - "Service/procedure not covered when performed in this place of service,"
- Claim Adjustment Reason Code (CARC) 58 - "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present," and,
- If the claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN is on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Your FI or MAC will pay *institutional* claims containing HCPCS 93797, 93798, G0422, and G0423 on Types of Bill (TOB) 13X under the Hospital Outpatient Prospective Payment System (OPPS) and 85X on reasonable cost. They will pay for CR/ICR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis (TOBs 13X) in accordance with the terms of the Maryland waiver. Claims for G0422 and G0423 from Method II critical access hospitals should be billed on TOB 85X with revenue codes 96X, 97X, or 98X.

They will deny claims for CR/ICR services (HCPCS codes 93797, 93798, G0422, and G0423) for services that are provided in other than TOBs 13X and 85X using:

- RARC N428 - "Service/procedure not covered when performed in this place of service,"
- CARC 58 - "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN is on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Your contractors will deny both professional and institutional claims for CR services that exceed two units per date of service, or six units per date of service for ICR, using:

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached,"
- RARC N362 - "The number of days or units exceeds our acceptable maximum," and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no

ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Medicare will pay for HCPCS codes 93797 and 93798 for CR services that exceed 36 sessions when the KX modifier is on the claim. However, Medicare contractors will deny claims for over 36 sessions of CR services without the KX modifier and, in doing so, will use the following:

- CARC 151 – “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services,”
- RARC N435 – “Exceeds number/frequency approved /allowed within time period without support documentation,” and,
- & If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.
- & Your contractors will deny ICR claims (G0422 and G0423) that exceed 72 sessions within 126 days from the date of the first session unless the modifier KX is on the claim. In denying such claims, they will use:
 - CARC 119 – “Benefit maximum for this time period or occurrence has been reached,”
 - RARC N435 – “Exceeds number/frequency approved /allowed within time period without support documentation,” and,
 - & If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Contractors will only pay for ICR services when submitted by providers enrolled as supplier specialty code 31 (intensive cardiac rehabilitation). ICR services submitted by providers enrolled as other than specialty code 31 will be denied using:

- CARC 8 – “The procedure code is inconsistent with the provider type/specialty (taxonomy). NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present,”
- RARC N95 – “This provider type may not bill this service,” and,
- If the claim is received with a GA modifier indicating a signed ABN is on file, Group Code PR (Patient Responsibility) is used or if the claim contains the GZ modifier indicating no ABN on file, Group Code CO (Contractual Obligation) is used to assign financial liability to the provider.

Finally, your contractors will not research and adjust any CR or ICR claims (HCPCS 93797, 93798, G0422, and G0423), processed prior to the implementation of CR 6850; however, they will adjust claims that you bring to their attention.

Additional Information

You can find more information about CR and ICR services by going to CR 6850, which was issued in four transmittals as follows:

- Transmittal R1974CP modified the Medicare Claims Processing Manual and is available at <http://www.cms.gov/Transmittals/downloads/R1974CP.pdf>;
- Transmittal R126BP modified the Medicare Benefit Policy Manual at '<http://www.cms.gov/Transmittals/downloads/R126BP.pdf>;

- Transmittal R339PI modifies the Medicare Program Integrity Manual at <http://www.cms.gov/Transmittals/downloads/R339PI.pdf>; and
- Transmittal R170FM modifies the Medicare Financial Management Manual at <http://www.cms.gov/Transmittals/downloads/R170FM.pdf> on the CMS website.

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

CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR OCTOBER 2010 ~CMS MLN Matters~

MLN Matters® Number: MM7057
Related CR Release Date: July 16, 2010
Related CR Transmittal #: R2001CP

Related Change Request (CR) #: 7057
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7057, which announces the changes that will be included in the October 2010 release of Medicare's edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in July 2010. Please ensure that your billing staffs are aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2, available at <http://www.cms.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 7057 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2010. These changes become effective for services furnished on or after October 1, 2010. The changes that are effective for dates of service on and after October 1, 2010 are as follows:

For Bacterial Urine Cultures:

- Add ICD-9-CM code 780.66 to the list of ICD-9-CM codes that are covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.

For Human Immunodeficiency Virus (HIV) Testing (Diagnosis):

- Add ICD-9-CM codes 780.66, 786.30, 786.31, and 786.39 to the list of ICD-9-CM codes that are covered by Medicare for the Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14) NCD.
- Delete ICD-9-CM code 786.3 from the list of covered ICD-9-CM codes for the Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14) NCD.

For Blood Counts:

- Add ICD-9-CM codes 832.2, V11.4, V25.11, V25.12, V25.13, V49.86, and V62.85 to the list of "Do Not Support Medical Necessity" ICD-9-CM codes that are covered by Medicare for the Blood Counts (190.15) NCD. '
- Delete ICD-9-CM code V25.1 from the list of covered "Do Not Support Medical Necessity" ICD-9-CM codes for the Blood Counts (190.15) NCD. '

For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 786.30, 786.31, and 786.39 to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes 275.0, 287.4, and 786.3 from the list of covered ICD-9-CM codes for the PTT (190.16) NCD.

For Prothrombin Time:

- Add ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 786.30, 786.31, 786.39, 999.80, 999.83, 999.84, and 999.85 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.
- Delete ICD-9-CM codes 275.0, 287.4, and 786.3 from the list of covered ICD-9-CM codes covered for the Prothrombin Time (190.17) NCD.
- Correct a typographical error by replacing ICD-9-CM code 531.21 with ICD-9-CM code 534.21 within the code range 534.20-531.21 for the Prothrombin Time (190.17) NCD.

For Serum Iron Studies:

- Add ICD-9-CM codes 237.73, 237.79, 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 999.80, 999.83, 999.84, and 999.85 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM codes 275.0 and 287.4 from the list of covered ICD-9-CM codes for the Serum Iron Studies (190.18) NCD.

For Blood Glucose Testing:

- Add ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 276.61, 276.69, 780.33, 787.60, 787.61, 787.62, and 787.63 to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD.
- Delete ICD-9-CM codes 275.0, 276.6, and 787.6 from the list of covered ICD-9-CM codes for the Blood Glucose Testing (190.20) NCD.

For Glycated Hemoglobin/Glycated Protein:

- Add ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 to the list of ICD-9-CM codes covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- Delete ICD-9-CM code 275.0 from the list of covered ICD-9-CM codes for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

For Lipids Testing:

- Add ICD-9-CM code 278.03 to the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD.

For Digoxin Therapeutic Drug Assay:

- Add ICD-9-CM codes 276.61 and 276.69 to the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay(190.24) NCD.
- Delete ICD-9-CM code 276.6 from the list of covered ICD-9-CM codes for the Digoxin Therapeutic Drug Assay (190.24) NCD.

For Alpha-fetoprotein:

- Add ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 to the list of ICD-9-CM codes covered by Medicare for the Alpha-fetoprotein (190.25) NCD.
- Delete ICD-9-CM code 275.0 from the list of covered ICD-9-CM codes for the Alpha-fetoprotein (190.25) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM codes 273.73, 237.79, 275.01, 275.02, 275.03, 275.09, 560.32, 780.66, 970.81, and 970.89 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM codes 275.0 and 970.8 from the list of covered ICD-9-CM codes for the Gamma Glutamyl Transferase (190.32) NCD.

For Hepatitis Panel/Acute Hepatitis Panel:

- Add ICD-9-CM code 780.33 to the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

For Fecal Occult Blood Test:

- Add ICD-9-CM codes 287.41, 287.49, and 560.32 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Delete ICD-9-CM code 287.4 from the list of covered ICD-9-CM codes for the Fecal Occult Blood Test (190.34) NCD.

Additional Information

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

The official instruction, CR 7057, issued to your Medicare carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2001CP.pdf> on the CMS website.

COLLAGEN MENISCUS IMPLANT ~CMS MLN Matters~

MLN Matters® Number: MM6903 &
Related CR Release Date: May 28, 2010 &
Related CR Transmittal #: R121NCD and R1977CP

Related Change Request (CR) #: 6903
Effective Date: May 25, 2010
Implementation Date: July 6, 2010

Provider Types Affected

This article is for physicians, non-physician practitioners (NPPs) and facilities that bill Medicare Carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs) for services related to the collagen meniscus implant procedure for Medicare beneficiaries.

What You Need to Know

This article pertains to change request (CR) 6903 and announces that **claims submitted for a collagen meniscus implant procedure will be denied**. Also, effective with the July updates of the Medicare Physician Fee Schedule Database (MPFSDB) and the Integrated Outpatient Code Editor (I/OCE), a new HCPCS code, G0428 (Collagen or other tissue engineered meniscus knee implant procedure for filling meniscal defects (e.g. collagen scaffold, Menaflex)), will be available for use in non-covering collagen meniscus implant procedure claims with dates of service on and after May 25, 2010.

Background

The Centers for Medicare & Medicaid Services (CMS) concluded that the evidence demonstrates that the collagen meniscus implant does not improve health outcomes. Thus, CMS determined that the collagen meniscus implant is not reasonable and necessary for the treatment of meniscal injury/tear and is non-covered by Medicare, as identified in section 150.12 of the National Coverage Determination (NCD) Manual. That section of the NCD manual is available as an attachment to CR 6903.

This is a new NCD as there was no existing NCD on collagen meniscus implants. On August 27, 2009, CMS initiated a national coverage analysis (NCA) on the collagen meniscus implant. The collagen meniscus implant is manufactured from bovine collagen and is used to fill a meniscal defect that results from a partial meniscectomy. CR 6903 communicates the findings of that analysis. Upon completion of a NCA for the collagen meniscus implant, the decision was made that the collagen meniscus implant is non-covered for Medicare beneficiaries.

Key Points of CR 6903

- Effective for dates of service on and after May 25, 2010, claims submitted for a collagen meniscus implant procedure will be denied.
- & In denying such claims, Medicare will use Claim Adjustment Reason Code 96 (Non-covered charge(s)) and Remittance Advice Remark Code N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.gov/mcd/search.asp> on the CMS website. If you do not have access, you may contact the local contractor to request a copy of the NCD.) In addition, Medicare contractors will use Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary if a signed Advance Beneficiary Notice

(ABN) is on file; otherwise, Group Code CO (Contractual Obligation) will be used assigning financial liability to the provider if no signed ABN is on file.

- & Your contractor will not search their files to recover payment for claims paid prior to implementing CR 6903. However, they will adjust such claims that are brought to their attention.

Additional Information

If you have questions, please contact your Medicare FI, carrier and/or MAC at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction, CR6903, issued to your Medicare FI, carrier and/or MAC regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R121NCD.pdf> (for the NCD manual revision) and <http://www.cms.gov/Transmittals/downloads/R1977CP.pdf> (for claims processing instructions) on the CMS website.

DEFINITION OF AMBULANCE SERVICES

~CMS MLN Matters~

MLN Matters® Number: MM7058 &
Related CR Release Date: July 30, 2010 &
Related CR Transmittal #: R130BP &

Related Change Request (CR) #: 7058
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This article applies to ambulance suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for ambulance services provided to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7058 which updates the Medicare Benefit Policy Manual (Chapter 10, Section 30.1.1) to incorporate the application of Basic Life Support (BLS) – Emergency; Advanced Life Support Level 1 (ALS1) and Emergency and Advanced Life Support Level 2 (ALS2) information. No new policy is presented but the CR7058 updates the relevant manual section to reflect current policy. The updated manual section is attached to Cr 7058.

Background

CMS issued MM7058 to update the relevant manual sections and provides the following application-based examples to accompany the definitions of BLS, ALS1 and ALS2 as follows:

Basic Life Support (BLS) Emergency:

Application: The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service,

then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced Life Support, Level 1 (ALS1) - Emergency

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advance Life Support, Level 2 (ALS2)

Application: Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3rd of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol, calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, in order to receive payment for an ALS2 level of service based in part on the administration of Epinephrine,

three separate administrations of Epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

Additional Information

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

The official instruction associated with this CR7058, issued to your Medicare A/B MAC, carrier and/or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R130BP.pdf> on the CMS website.

DERMAL INJECTIONS FOR TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS)

~CMS MLN Matters~

MLN Matters® Number: MM6953
Related CR Release Date: June 4, 2010
Related CR Transmittal #: R122NCD and R1978CP

Related Change Request (CR) #: 6953
Effective Date: March 23, 2010
Implementation Date: July 6, 2010

Provider Types Affected

This article is for physicians, hospitals, and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for Facial Lipodystrophy services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 6953, which informs Medicare contractors that effective for claims with dates of service on and after March 23, 2010, dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only

in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Background

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial lipodystrophy syndrome (LDS) for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

Nationally Covered Indications

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Nationally Non-Covered Indications

- Dermal fillers that are not approved by the FDA for the treatment of LDS, and
- Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

Claims Coding/Pricing Information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare Physician Fee Schedule (MPFS), and the July Integrated Outpatient Code Editor (IOCE):

- HCPCS codes Q2026, Q2027, and G0429 will be designated for dermal fillers Sculptra® and Radiesse®;
- HCPCS codes Q2026, Q2027, and G0429 are effective for dates of service on or after March 23, 2010;
- HCPCS codes Q2026 and Q2027 are contractor-priced under the July MPFS; and
- HCPCS code G0429 is payable under the July MPFS.

However, because HCPCS Q2026, Q2027 and G0429 are not considered valid HCPCS until implementation of the July 2010 HCPCS update, providers will not be able to bill and receive payment for these HCPCS codes prior to July 6, 2010.

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

For hospital institutional non-OPPS claims, Medicare contractors will use current payment methodologies for claims for dermal injections for treatment of LDS.

Hospital and ASC Billing Instructions

For hospital **outpatient claims, hospital institutional non-OPPS claims**, and ASCs, covered dermal injections for treatment of LDS must be billed by having all the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a Line Item Date of service (LIDOS) on or after March 23, 2010;
- A line with HCPCS code G0249 with a LIDOS on or after March 23, 2010; and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

Medicare will line item deny institutional claims where the LIDOS is prior to March 23, 2010.

Note to OPPS hospitals or ASCs: For line item dates of service on or after March 23, 2010, and until pricing information is made available to price OPPS claims, LDS claims will contain the temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

Note on all hospital claims: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

Practitioner Billing Instructions

Practitioners must bill covered claims for dermal injections for treatment of LDS by having all the required elements on the claim:

- A date of service (LIDOS) on or after March 23, 2010;
- HCPCS codes Q2026 or Q2027;
- A line with HCPCS code G0249; and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

NOTE: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage based on the individual Medicare contractor's policy.

Billing for Services Prior to Medicare Coverage

ASCs and practitioners billing for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- Group Code: Contractual Obligation (CO)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following Medicare Summary Notice (MSN) message upon the Medicare denial:

- 21.11 - This service was not covered by Medicare at the time you received it.

Billing for Services Not Meeting Comorbidity Coverage Requirements

Hospitals and practitioners billing for dermal injections for treatment of LDS on patients that do not have on the claim both ICD-9-CM diagnosis codes of 042 and 272.6, indicating HIV and lipodystrophy will receive the following messages upon their Medicare claims denial:

- CARC 50: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- & RARC M386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- & Group Code: Contractual Obligation (CO)

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of LDS will receive the following MSN message upon the Medicare denial:

- 15.4 - *The information provided does not support the need for this service or item.*

Additional Information

The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the *Medicare NCD Manual* and it may be viewed at <http://www.cms.gov/transmittals/downloads/R122NCD.pdf> on the CMS website. The second transmittal revises the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R1978CP.pdf> on the CMS website.

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

**IMPLEMENTATION OF THE INTERRUPTED STAY POLICY UNDER
THE INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT
SYSTEM (IPF PPS)
~CMS MLN Matters~**

MLN Matters® Number: MM7044 &
Related CR Release Date: July 29, 2010 &
Related CR Transmittal #: R2009CP &

Related Change Request (CR) #: 7044
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

This article is for Inpatient Psychiatric Facilities (IPFs) submitting claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7014 in response to the findings of the report issued by the Office of Inspector General (OIG) entitled: *Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007*, (A-01-09-00508). Based on findings in this report, CMS is implementing the interrupted stay policy where the patient is admitted to another IPF before midnight on the third consecutive day following discharge from the original IPF stay.

Background

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented in January 2005. One aspect of the IPF PPS included an interrupted stay policy.

Key Points of CR 7044

- & An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay.
- Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment regardless if the interrupted stay is to the same IPF or not.
- Interrupted stays are considered to be continuous in determining outlier payments only when the interrupted stay is to the same IPF.
- In other words, an interrupted stay is treated as one stay and one discharge for the purpose of the IPF PPS payment.
- & Medicare system edits will be put in place to identify claims that qualify as interrupted stays by examining incoming claims and comparing them to other IPF claims in Medicare's claims history files.
- & When Medicare detects a claim that shows an interrupted stay, the Medicare contractor will adjust the appropriate claim(s) (including claims in history, if necessary) in date of service sequence order to reflect a reduction in payment due to the variable per diem adjustment being applied from an interrupted stay.
- & When Medicare performs the above adjustment, it will use the following messages to alert the IPF:

- Claim Adjustment Reason Code of 45 (Contractual Adjustment);
- Remittance Advice Remark Code of NXX (PPS (Prospect Payment System) payment adjusted during adjudication. Variable per diem adjustment changed due to interrupted stay policy.); and
- Contractual Obligation Code of CO.

Additional Information

If you have questions, please contact your Medicare FI or AB MAC at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction associated with this CR7044, issued to your Medicare FI or AB MAC regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R2009CP.pdf> on the CMS website.

To review a Fact Sheet discussing the IPF PPS, go to

<http://www.cms.gov/MLNProducts/downloads/InpatientPsychFac.pdf> on the CMS website.

MAGNETIC RESONANCE ANGIOGRAPHY (MRA)

~CMS MLN Matters~

MLN Matters® Number: MM7040

Related CR Release Date: July 9, 2010

Related CR Transmittal #: R1998CP and R123NCD

Related Change Request (CR) #: 7040

Effective Date: June 3, 2010

Implementation Date: August 9, 2010

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), carriers, and A/B Medicare Administrative Contractors (MAC)) for Magnetic Resonance Angiography (MRA) services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7040. You need to know that, effective for claims with dates of services on or after June 3, 2010, Medicare contractors will have the discretion to cover or not cover all indications of MRA (and magnetic resonance imaging (MRI)) that are not specifically nationally covered or nationally non-covered. Existing national coverage for both MRI and MRA will be maintained. Please ensure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) in October, 1995, set forth the original conditions under which MRA would be covered. Revisions to the national coverage determination (NCD) policy took place in 1997, 1999, and 2003 to expand coverage for additional indications. Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. All other uses of MRA are nationally non-covered unless coverage is specifically indicated.

In addition, CMS recently reconsidered the NCD for MRI at section 220.2 of the NCD Manual and removed national non-coverage for MRI for blood flow determination, thereby permitting local Medicare contractors to make local coverage determinations within their respective jurisdictions effective for claims with dates of service on or after June 3, 2010. Such local determinations would apply to all indications of MRA/MRI that are not specifically covered nationally or non-covered nationally.

While reviewing published scientific evidence for the MRI reconsideration, CMS became aware of evidence that may speak to currently non-covered indications for MRA. As a result, CMS initiated this reconsideration to evaluate the current evidence for the non-covered indications for the MRA NCD at section 220.3.C of the NCD Manual.

MRA is a specific application of MRI. CMS believes that the continued existence of separate NCDs is unnecessary, and that the provisions of the MRA NCD at section 220.3 should be merged under the NCD for MRI at section 220.2. Thus, section 220.3, MRA, of the NCD Manual, will no longer appear as a separate NCD.

The effect of this change will maintain existing national coverage for both MRI and MRA, and will eliminate the non-coverage language that currently exists for MRA at section 220.3.C of the NCD Manual, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally non-covered.

Additional Information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction, CR 7040, was issued to your Medicare contractor via two transmittals. The first transmittal modifies the NCD Manual as discussed above and that transmittal is available at <http://www.cms.gov/Transmittals/downloads/R123NCD.pdf> on the CMS website. The second transmittal updates the Medicare Claims Processing Manual and that is available at <http://www.cms.gov/Transmittals/downloads/R1998CP.pdf> on the CMS website.

PULMONARY REHABILITATION (PR) SERVICES

~CMS MLN Matters~

MLN Matters® Number: MM6823
Related CR Release Date: May 7, 2010
Related CR Transmittal #: R124BP and R1966CP

Related Change Request (CR) #: 6823
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs) and/or carriers) for pulmonary rehabilitation (PR) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6823 which alerts providers that the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added payment and coverage improvements for patients with chronic obstructive pulmonary disease (COPD) and other conditions effective January 1, 2010. As a result, Medicare provides a covered benefit for a comprehensive PR program under Medicare Part B effective for services on or after January 1, 2010. Be certain your billing staffs are aware of these Medicare changes and of the claims processing system changes to handle claims for PR services that must be implemented no later than October 4, 2010.

Background

Pulmonary Rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment who are symptomatic and often have decreased daily life activities.

A PR program is individually tailored and designed to optimize physical and social performance and autonomy. The program must provide an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory impairment. In September 2007, the Centers for Medicare & Medicaid Services (CMS), in its final decision memorandum for PR Services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS did (and still does) cover medically reasonable and necessary respiratory treatment services in Comprehensive Outpatient Rehabilitation Facilities (CORFs), as well services to patients with respiratory impairments who are not eligible for PR but for whom local contractors determine respiratory treatment services are covered. MIPPA added payment and coverage improvements for patients with COPD and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law authorizes a PR program, which was codified in the Physician Fee Schedule calendar year 2010 final rule at 42 CFR 410.47.

Key Points of CR 6823

Effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program. Medicare will pay for up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of PR. The PR program must include the following mandatory components:

1. Physician-prescribed exercise;
2. Education or training;
3. Psychosocial assessment;
4. Outcomes assessment; and
5. An individualized treatment plan.

The following bullet points detail Medicare claims processing requirements for PR services furnished on or after January 1, 2010:

- Effective January 1, 2010, Medicare contractors will pay claims containing Healthcare Common procedure Coding System (HCPCS) code G0424 when billing for PR services, including exercise and monitoring, as described in the Medicare Benefit Policy Manual, Chapter 15, section 231, as revised by CR 6823, and the Medicare Claims Processing

Manual, Chapter 32, Section 140, as revised by CR 6823. These revised documents are attached to CR 6823, which is available at

<http://www.cms.gov/Transmittals/downloads/R124BP.pdf> (Benefit Policy Manual) and <http://www.cms.gov/Transmittals/downloads/R1966CP.pdf> (Claims Processing Manual) on the CMS website.

- Medicare contractors will pay claims for HCPCS code G0424 (PR) only when services are provided in the following places of service (POS): 11 (physician's office) or 22 (hospital outpatient). Medicare will deny claims for HCPCS code G0424 performed in other than, and billed without, POS 11 or 22, using the following:
 - Claim Adjustment Reason Code (CARC) 58 – “treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
 - Remittance Advice Remark Code (RARC) N428 – “Service/procedure not covered when performed in this place of service.”
 - Group Code PR (Patient Responsibility) assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file or Group Code CO (Contractual Obligation) assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- & Medicare contractors will pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on Types of Bill (TOB) 13X and 85X under reasonable cost.
- & Contractors will pay for PR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission on an outpatient basis, TOB 13X, in accordance with the terms of the Maryland waiver.
- Contractors will deny claims for PR services provided in other than TOB 13X and 85X using the following:
 - CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
 - RARC N428 – “Service/procedure not covered when performed in this place of service.”
 - Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- & Using the Medicare Physician Fee Schedule, Medicare contractors will also pay for PR services billed with HCPCS code G0424 and revenue code 096X, 097X, or 098X on TOB 85X from Method II critical access hospitals (CAHs).
- Medicare will deny PR services that exceed two units on the same date of service and, in doing so, will use the following:
 - CARC 119 – “Benefit maximum for this time period or occurrence has been reached.”
 - RARC N362 – “The number of days or units of service exceeds our acceptable maximum.”
 - Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

- & Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes a KX modifier. Claims for HCPCS code G0424 which exceed 36 sessions without the KX modifier will be denied using the following:
 - CARC 151 – “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.”
 - & Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- & Medicare contractors will deny claims for HCPCS code G0424 when submitted for more than 72 sessions even where the KX modifier is present. In the denials, contractors will use the following:
 - CARC B5 - “Coverage/program guidelines were not met or were exceeded.”
 - Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or Group Code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

Additional Information

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

CR6823 was issued to your Medicare MAC, FI, or carrier in two transmittals. One transmittal modifies the Medicare Benefit Policy Manual and that transmittal is available at <http://www.cms.gov/Transmittals/downloads/R124BP.pdf> on the CMS website. The second transmittal modifies the Medicare Claims Processing Manual and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R1966CP.pdf> on the CMS website.

For related detailed policy and claims processing instructions issued December 11, 2009, you may review MM6715 at <http://www.cms.gov/MLNMattersArticles/downloads/MM6751.pdf> on the CMS website.

REVISIONS AND RE-ISSUANCE OF AUDIOLOGY POLICIES

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6447 Revised
Related CR Release Date: July 23, 2010
Related CR Transmittal #: R129BP and R2007CP

Related Change Request (CR) #: 6447
Effective Date: August 11, 2010
Implementation Date: August 11, 2010

Note: This article was revised on July 26, 2010, to include revised effective and implementation dates, a revised CR release date, transmittal numbers, and web addresses for accessing the transmittals. In addition, Claim Adjustment Reason Codes and Remittance Advice Remark Codes have been added, where appropriate. The web address for accessing the Audiology code list was also revised. All other information is the same.

Provider Types Affected

This article is for physicians, non-physician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare Administrative Contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6447. The Centers for Medicare & Medicaid Services (CMS) issued CR 6447 to respond to provider requests for clarification of some of the language in CR5717 and CR6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare Physician Fee Schedule (MPFS). See the *Key Points* section below for the clarifications provided by CR6447.

Background

Key parts of the clarified policy are in the revised Chapter 12, Section 30.3 of the Medicare Claims Processing Manual and in Chapter 15, Section 80.3 of the Medicare Benefit Policy Manual. These revised manual sections are attached to CR 6447. As mentioned in these revised sections of the manuals and per Section 1861 (II) (3) of the Social Security Act, “audiology services” are defined as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician. These hearing and balance assessment services are termed “audiology services,” regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

Note: References to technicians in CR 6447 and this article apply also to other qualified clinical staff. The qualifications for technicians vary locally and may also depend on the type of test, the patient, and the level of participation of the physician who is directly supervising the test. Therefore, an individual must meet qualifications appropriate to the service furnished as determined by the Medicare contractor to whom the claim is billed. If it is necessary to determine whether the individual who furnished the labor for appropriate audiology services is qualified, contractors may request verification of any relevant education and training that has been completed by the technician, which shall be available in the records of the clinic or facility.

Audiology services, like all other services, should be reported under the most specific HCPCS code that describes the service that was furnished and in accordance with all CPT guidance and Medicare national and local contractor instructions.

See the CMS website at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp for a listing of all CPT codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at <http://www.cms.gov/PFSlookup/> allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

Qualifications Discussion

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test;
- Development and modification of the test battery and test protocols;
- Clinical judgment, assessment, evaluation, and decision-making;
- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes;
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contralateral masking; and/or
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss

Key Points of CR 6447

- For claims with dates of service on or after October 1, 2008 audiologists are required to be enrolled in the Medicare program and use their National Provider Identifier (NPI) on all claims for services they render in office settings.

- & For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital Outpatient Prospective Payment System (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.
- & Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- & When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- & Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services as shown in Chapter 15, Section 80.3 of the Medicare Benefit Policy manual as attached to CR 6447.
- & For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician. In denying such claims, Medicare will use:
 - CARC 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
 - Remittance Advice Remark Code (RARC) MA102 (Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.)
- & Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills. Such claims will be denied using Claim Adjustment Reason Code (CARC) 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.).
- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
 - CARC 185 (The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
 - RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.)
- & Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified

to perform the service. (Once again, the list of audiology services is posted at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp on the CMS website.)

- & Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp and are not "always" therapy services and the audiologist is qualified to perform the service.
- & All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- & The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
- & When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- & The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- & The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.
- & The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- & The opt out law does not define "physician" or "practitioner" to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

Additional Information

There are two transmittals related to CR6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the Medicare Benefit Policy Manual and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R129BP.pdf> on the CMS

website. The other transmittal modifies the Medicare Claims Processing Manual and it is at <http://www.cms.gov/Transmittals/downloads/R2007CP.pdf> on the CMS website.

If you have questions, please contact your Medicare A/B MAC, FI or carrier at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

ROUTINE FOOT CARE - LCD L30322 (FT-001): UTILIZATION GUIDELINES

Please note that the Routine Foot Care Local Coverage Determination (LCD) L30322 - FT-001 has utilization guidelines. WPS denies services submitted less than 60 days apart. If you have a claim deny, you will need to submit a redetermination request with documentation showing the medical necessity of the service in order to have the services reviewed.

SCREENING FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6786 Revised
Related CR Release Date: March 23, 2010
Related CR Transmittal #: R1935CP and R113NCD

Related Change Request (CR) #: 6786
Effective Date: December 8, 2009
Implementation Date: July 6, 2010

Note: This article was revised on May 21, 2010, to correct the diagnosis codes in the first paragraph on page 3 to include V as the first position of those codes and to change the procedure code on page 4 to 87999 from 99199. As a result of a new CR, the CR release date, transmittal number, and web address for addressing the CR were changed. All other information is the same.

Provider Types Affected

This article is for all physicians, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors (Fiscal Intermediaries (FI), carriers, and Parts A/B Medicare Administrative Contractors (A/B MAC)) for services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for HIV infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CAUTION – What You Need to Know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the National Coverage

Determination (NCD) Manual, sections 190.14 and 210.7, and the Medicare Claims Processing Manual (CPM), chapter 18, section 130. These manual sections are attached to the transmittals, which comprise CR 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

GO – What You Need to Do

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

Background

Effective January 1, 2009, the CMS is authorized to add coverage of “additional preventive services” through the NCD process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786. **NOTE:** 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.
- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman’s clinician.

NOTE: Three tests will be covered for each term of pregnancy beginning with the date of the first test. .

The USPSTF guideline upon which this policy is based contains 8 increased-risk criteria. The first 7 require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

NOTE: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following 3 new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 Outpatient Code Editor and the January 2011 Clinical Laboratory Fee Schedule (CLFS) updates:

- G0432 - Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening,
- G0433 - Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening, and,

- & G0435 - Infectious agent antigen detection by rapid antibody test of oral mucosa ' transudate, HIV-1 or HIV-2, screening. '

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030X for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached.) will be used.

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (Types of Bills 12X, 13X, or 14X) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Prior to inclusion of the new G Codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009 through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional Information

CR 6786 was issued in two transmittals, one which modifies the *Medicare Claims Processing Manual*, which is at <http://www.cms.gov/Transmittals/downloads/R1935CP.pdf> on the CMS website. The second transmittal revises the Medicare National Coverage Determinations Manual and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R113NCD.pdf> on the CMS website.

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

USUALLY SELF-ADMINISTERED DRUG (SAD) LIST

The list of Usually Self-Administered Drugs (SAD) has been updated in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD) as of September 1, 2010 at <http://www.cms.gov/mcd/overview.asp>. The list is also available on our website. To view the entire list, please visit the appropriate web page for your Medicare contract:

J5 MAC Part A: http://wpsmedicare.com/j5macparta/policy/usad_listing/

Legacy Part A: http://www.wpsmedicare.com/part_a/policy/sad_drugs.shtml

Coverage – Policies

INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), as well as retired LCDs for Medicare Part A, on its website:

J5 MAC (IA, KS, MO, NE): <http://www.wpsmedicare.com/j5macparta/policy/>

Legacy: http://www.wpsmedicare.com/part_a/policy/index.shtml

If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LCD by writing to our Freedom of Information (FOI) Unit.

Part A Legacy (All Regions)
<p>WPS Medicare Medicare Medical Review Attn: Medical Review Supervisor P.O. Box 1602 Omaha, NE 68101</p>

Part A MAC (IA, KS, MO, NE)	
Iowa	Kansas
<p>WPS Medicare Part A Freedom of Information P.O. Box 7665 Madison, WI 53707-7665</p>	<p>WPS Medicare Part A Freedom of Information P.O. Box 7576 Madison, WI 53707-7576</p>
Missouri Nebraska	
<p>WPS Medicare Part A Freedom of Information P.O. Box 8890 Madison, WI 53707-8890</p>	<p>WPS Medicare Part A Freedom of Information P.O. Box 8799 Madison, WI 53708-8799</p>



New Policies

The following are new policies. Be sure to note the effective date of the new policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

<http://www.cms.gov/mcd/indexes.asp?from2=indexes.asp&>

Visit our website at the appropriate link below for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macparta/policy/updates/new/>

Legacy: http://www.wpsmedicare.com/part_a/policy/updates/new/index.shtml

July 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Bariatric Surgery for Morbid Obesity	NA	GSURG-042	08/01/2010
	This WPS document is a copy of the NCD on this topic and has attached coding and billing guidelines. GSURG-042 can be found on the WPS Medicare Policy website.			

August 2010

There are no new policies.

September 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Fluorescein or Indocyanine Green Angiography	L30727	OPHTH-016	10/16/2010
Leg/ MAC	Psychiatric Partial Hospitalization Program (PHP)	L30491	PSYCH-016	10/16/2010

Retired Policies

The following are retired policies. Be sure to note the effective date of the retired policy, as the policy will not appear as retired until the effective date.

Visit our website at the appropriate link below for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macparta/policy/updates/retired/>

Legacy: http://www.wpsmedicare.com/part_a/policy/updates/retired/index.shtml

July 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
MAC	Bariatric Surgery	L26558	N/A	07/31/2010
	This LCD is retired effective 07/31/2010 and replaced with a WPS-maintained document entitled "Bariatric Surgery for Morbid Obesity" (GSURG-042). This copy of the NCD with coding and billing instructions can be found on the WPS Policy website. Instructions can also be found in CMS IOM Publications 100-3 §100.1 and 100-4, Chapter 32, §150.			

August 2010

There are no retired policies.

September 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
MAC	Outpatient Hospital Psychiatric Services	L26575	N/A	10/15/2010
Leg/ MAC	Psychiatric Partial Hospitalization Program	L2403 L26611	N/A	10/15/2010
	This LCD will be retired and replaced by L30491			

Revised Policies

The following are new policies. Be sure to note the effective date of the revised policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

<http://www.cms.gov/mcd/indexes.asp?from2=indexes.asp&>

Visit our website at the appropriate link below for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macparta/policy/updates/revised/>

Legacy: http://www.wpsmedicare.com/part_a/policy/updates/revised/index.shtml

July 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
MAC	Chemotherapy Drugs and their Adjuncts CPT/HCPCS Codes Indications and Limitations of Coverage and/or Medical Necessity 20. Fludarabine Phosphate (Fludara) 50 mg (J9185) Peripheral stem cell transplant V42.82 47. Vinorelbine tartrate (Navelbine) per 10 mg (J9390) Mesothelioma 163.0, 163.1, 163.8, 163.9	L28576	HONC-010	07/01/2010
Leg/ MAC	Epidural and Transforaminal Epidural Injections Anti-spasmodic drugs administered intrathecally (e.g., baclofen) to treat chronic intractable spasticity are addressed in the Infusion Pump NCD Pub. 100-3 Sec. 280.14. The CPT description of procedure codes 62310, 62311, 62318 and 62319 include anesthetic, antispasmodic, opioid, steroid, other solution; therefore the spasticity conditions are included in this LCD. ICD-9 codes 340, 342.10-342.12, 343.0-343.9, 344.00-344.5, 728.85, and 781.0 were added effective 04/15/2010.	L30481	NEURO-007	04/15/2010
Leg/ MAC	Flow Cytometry ICD-9 Codes that Support Medical Necessity The coding is corrected as follows: *285.6 replaces 285.9	L30161	PATH-016	11/16/2009
Leg/ MAC	Immune Globulins The following ICD-9 codes were added to the LCD: 694.4 pemphigus 694.5 pemphigoid 694.60 benign mucous membrane pemphigoid without ocular involvement 694.61 benign mucous membrane pemphigoid with ocular involvement 694.8 other specified bullous dermatoses Indications and Limitations of Coverage and/or Medical Necessity B. 29. Autoimmune mucocutaneous blistering disease is covered by a National Coverage Determination (See IOM Pub. 100-3: Medicare National Coverage Determination Manual Chapter 1, Part 4 Section 250.3) (694.4, 694.5, 694.60, 694.61, 694.8)	L30147	INJ-012	07/01/2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Podiatry Code List	N/A	N/A	N/A
	<p>The WPS medical director staff added the following procedure codes to the list of HCPCS codes approved as payable for podiatrists.</p> <p>CPT code 89060 - Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)</p> <p>CPT code 97112 - Neuromuscular re-education of movement, balance, coordination etc, will be added to the Podiatry list.</p> <p>Note: CPT code 97112 may be billed when personally performed by a physician or a physical therapist. It may not be billed under the 'incident to' benefit when the service is performed by an employee who is not a physical therapist.</p>			
Leg/ MAC	Psychiatry and Psychology Services	L30489	PSYCH-014	3/18/2010
	CPT code 90870 removed from this LCD. See L30493, Electroconvulsive Therapy, PSYCH-025 for services on and after 07/16/2010.			
Leg/ MAC	Psychiatry and Psychology Services	L30489	PSYCH-014	07/01/2010
	<p>*Documentation:</p> <p>The medical record must document the conditions described under "description" relative to CPT codes 90846, 90847 and 90849. <u>Documentation must be available and will be requested prior to payment. If the claim does not indicate that document is available it will be denied.</u> (underlined added to LCD to reinforce importance of documentation.)</p> <p>Added ICD-9 codes 296.11-296.15, 296.80-296.82, 304.71-304.72, 313.89, V62.84</p>			

August 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Bariatric Surgery for Morbid Obesity	NA	GSURG-042	01/01/2010
	<p>08/01/2010: Added in the Billing and Coding Guidelines, under Non-Covered Bariatric Surgery Procedures the following statements that have an asterisk:</p> <p>WPS Medicare will process non-covered <i>outpatient</i> bariatric surgery claims according to the conditions outlined below:</p> <ol style="list-style-type: none"> 1. CPT procedure code 43842 will be denied when used for: open vertical banded gastroplasty. 2. CPT NOC code 43999 will be denied when used for: <ul style="list-style-type: none"> Laparoscopic vertical banded gastroplasty. Open sleeve gastrectomy. Laparoscopic sleeve gastrectomy. Open adjustable gastric banding. <p>*CPT code 43775 was added to the 2010 CPT/HCPCS Codes for a laparoscopic sleeve gastrectomy.</p> <p>*CPT code 43775 is considered noncovered and will be denied based on CMS Publication 100-03, <i>Medicare National Coverage Determinations Manual</i>, Chapter 1, Section 100.1.</p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Bone Mass Measurement Coding and Billing Guidelines	L28527	MS-004	08/01/2010
	*08/01/2010, Reinstated ICD-9-CM codes V58.65, V58.69 and V67.51 for the purpose of reporting conditions described under Indications and Limitations, section B. Effective from 03/18/2009			
MAC	Chemotherapy Drugs and their Adjuncts	L28576	HONC-010	See below
	<p>Indications and Limitations of Coverage and/or Medical Necessity</p> <p>D. Not otherwise Classified Agents (NOC) (J3590, J9999, C9399)</p> <p>Provenge® (sipuleucel-T) (J3590/C9399) effective 04/29/10 FDA approval date This is an autologous cellular immunotherapy indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer (185).</p> <p>Patients receiving sipuleucel-T infusions will have been to a pheresis center for leukapheresis. The individual patient lymphocytes will be used to manufacture a patient-specific medication (autologous cellular therapy), which when infused back into the patient (usually three days after leukapheresis) will stimulate a positive immunogenic response against his prostate cancer.</p> <p>Provenge is administered as three infusions, generally two weeks apart. Provenge should be administered via intravenous infusion over a period of approximately 60 minutes. The patient cannot be getting simultaneous chemotherapy and should not be getting immunosuppressive therapy.</p> <p>We will develop for documentation on the first infusion. Documentation should include:</p> <ol style="list-style-type: none"> 1. Documentation in the chart would demonstrate the patient was asymptomatic or minimally symptomatic and had metastatic castrate resistant (hormone refractory) disease. 2. Evidence of metastases to soft tissue or bone 3. Testosterone levels < 50ug or below lowest level of normal 4. Two sequential rising PSA levels obtained 2-3 weeks apart or other evidence of disease progression <p>We will only develop for the first infusion. Medicare will allow a maximum of three infusions per lifetime.</p> <p>E. Monoclonal Antibodies that are useful in chemotherapeutic regimens: Effective 07/01/2010:</p> <ol style="list-style-type: none"> 1. Rituximab (Rituxan) 100 mg, (J9310) Wegener's granulomatosis 446.4 			
Leg	Flow Cytometry	L30161	PATH-016	11/16/2009
	<p>ICD-9 Codes that Support Medical Necessity The following information was in error: The coding is corrected as follows: 285.6 replaces 285.9 The correct codes for the policy are: 285.9 and 785.6</p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg	Human Granulocyte/Macrophage Colony Stimulating Factors	L30306	INJ-019	08/01/2010
	We have clarified our coverage on dose intervals: Utilization Guidelines Dose dense chemotherapy treatment schedules and other chemotherapy regimens with cycle intervals of less than 3 weeks, such as those with 2 week intervals, will be allowed where literature supports its use.			

September 2010

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Botulinum Toxin Type A & Type B	L28555	INJ-018	09/01/2010
	09/01/2010, six, added ICD-9 codes 596.54, 596.55 when billed with CPT code 53899, 64614 or 64647 with an effective date of 05/16/2009.			
MAC	Chemotherapy Drugs and their Adjuncts	L28576	HONC-010	See below
	Indications and Limitations of Coverage and/or Medical Necessity C. The following drugs are covered for the following indications -effective 09/01/2010 18. Doxorubicin Hydrochloride, all lipid formulations, 10 mg (Doxil) (J9001) Malignant neoplasm of connective and other soft tissue-trunk 171.0-171.9 28. Irinotecan (Camptosar) 20 mg (J9206) Ewing's Sarcoma 170.0-170.9 D. Not otherwise Classified Agents (NOC) (J3590, J9999, C9399) 3. Jevtana® (Cabazitaxel) (J9999/C9399) effective 07/17/10 FDA approval date Microtubular inhibitor indicated in combination with prednisone for treatment of hormone refractory metastatic prostate cancer (185) previously treated with a docetaxel containing regimen.			
Leg/ MAC	Human Granulocyte/Macrophage Colony Stimulating Factors	L30306	INJ-019	09/01/2010
	ICD-9 codes 202.00-202.08 have been added to the following indication. D. Indications for Sargramostim (Leukine) (J2820): 2. Acceleration of myeloid recovery in patients with non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL) and Hodgkin's disease undergoing autologous bone marrow transplantation (BMT). Indicate this by coding the BMT (V42.81) and NHL (202.00-202.08, 202.80-202.88) or ALL (204.00, 204.02) or Hodgkin's disease (201.40-201.98).			
Leg/ MAC	Psychiatry and Psychology Services	L30489	PSYCH-014	09/01/2010
	Added ICD-9 278.01 Morbid Obesity			

Electronic Data Interchange (EDI)**5010 IMPLEMENTATION--PROCESSING ADDITIONAL
INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION-
CLINICAL MODIFICATION (ICD-9-CM) DIAGNOSIS AND
PROCEDURE CODES IN PRICER, GROUPER, AND THE MEDICARE
CODE EDITOR (MCE)**

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM7004 Revised
Related CR Release Date: August 13, 2010
Related CR Transmittal #: R2028CP

Related Change Request (CR) #: 7004
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: This article was revised on August 16, 2010, to reflect the revised CR 7004, which was issued on August 13, 2010. In this article, the CR release date, transmittal number (see above), and the web address for accessing CR 7004 were revised. All other information is the same.

Provider Types Affected

This article is for providers, hospitals and Skilled Nursing Facilities (SNFs) who submit claims to **Part A/B** Medicare Administrative Contractors (A/B MACs) and/or Fiscal Intermediaries (FIs) for services to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7004 to alert providers that with the implementation of the 5010 837I in January of 2011 providers can report up to 25 ICD-9-CM Diagnosis and up to 25 ICD-9-CM Procedure Codes. Be sure you are ready for the new standards.

Key Points

Changes are being made to the Inpatient Prospective Payment System (IPPS), Inpatient Psychiatric Facility (IPF) PPS and the Skilled Nursing Facility (SNF) Pricers, and to the Fiscal Intermediary Standard System (FISS) to allow these additional codes to be processed. In addition, the FISS interface to the Grouper and Medicare Code Editor (MCE) will be changed. The Grouper and MCE will be able to process more ICD-9-CM codes to determine the Medicare Severity Diagnosis Related Group (MS-DRG)

Background

The Administrative Simplification provisions of Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the Secretary of Health & Human Services to adopt standard electronic transactions and code sets for administrative health care transactions. The purpose of CR 7004 is to make the necessary base FISS changes related to various Pricers, Grouper, and the MCE to accommodate the changes in data content for the next version of HIPAA.

Additional Information

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

The official instruction associated with this CR7004, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2028CP.pdf> on the CMS website.

**ADDITIONAL INSTRUCTION FOR IMPLEMENTATION OF HEALTH
INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
(HIPAA) VERSION 5010 FOR TRANSACTION 835 - HEALTH CARE
CLAIM PAYMENT/ADVICE AND UPDATED STANDARD PAPER
REMIT (SPR)
~CMS MLN Matters~**

MLN Matters® Number: MM6975
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R709OTN

Related Change Request (CR) #: 6975
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, providers and suppliers who bill Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Regional Home Health Intermediaries (RHHI)), for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6975 to alert providers that, according to the Administrative Simplification provisions of HIPAA Regulations, the Secretary of the Department of Health and Human Services (DHHS) is required to adopt standard electronic transactions and code sets. CMS is currently in the process of implementing the next version of the HIPAA Transaction 835 standard – referred to as 835v5010 in this document. **Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.**

Key Points of CR6975

The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective Date of the regulation: March 17, 2009;
- Level I compliance by: December 31, 2010;
- Level II Compliance by: December 31, 2011; and
- All covered entities have to be fully compliant on: January 1, 2012.

Background

Level I compliance means “that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.”

Level II compliance means that a “covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.”

CMS will be fully compliant on January 1, 2012, by completing Level I compliance by December 31, 2010, and Level II compliance by December 31, 2011. **The transition period when both versions would be allowed in production mode for Medicare will be from January 1, 2011 – December 31, 2011. The 835v4010A1 and the current Standard Paper Remittance (SPR) should not be sent on or after January 1, 2012, irrespective of the date of receipt or date of service reported on the electronic or paper claim.**

Additional Information

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

The official instruction associated with this CR6975, issued to your Medicare Carrier, A/B MAC, FI and/or RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R709OTN.pdf> on the CMS website.

CHANGE IN 837 4010 EMC PRE-PASS EDITING MSP AND OTHER PAYER APPROVED/ALLOWED AMOUNTS

The electronic media claims (EMC) system reviews every claim for a number of pre-pass edits to ensure that claim data is valid. If a claim contains missing or incorrect information, one of two things will happen because of a pre-pass edit.

1. If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and alerts the submitter in order to correct future claims.
2. If a delete edit is in effect, the claim, batch, or file will NOT process normally; it deletes from the claims processing system and alerts the submitter to the error.

Electronic Medicare Secondary Payer (MSP) claims will require that the primary approved/allowed amount must be greater or equal the primary paid. Pre-pass editing will validate that the other payer approved amount fields as compared to the other payer paid amount field when both values are submitted. Effective September 6, 2010, electronic MSP claims that do not meet this condition will be deleted and not processed.

Edit Loop	Description	Edit Logic
M433 2400/AMT0 2	Other payer approved/allowed and paid amounts. Primary approved/allowed must be greater than or equal to the primary paid.	The edit will sets if; a 2400/AMT loop segment is present with AMT01=AAE; 2430/SVD loop segment is present and the allowed amount submitted in 2400/AMT02 is less than the paid amount submitted in 2430/SVD02. Note: Zeroes are valid dollar amounts for this edit.

It is important that you receive and review your pre-pass reports. A complete list of current 4010A1 pre-pass edits, as well as a detailed description, is available on the following WPS EDI website:

http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf

If you need additional information, you may also contact the WPS EDI Hotline:

J5 MAC: 866-503-9670

Legacy: 866-734-6656

CLAIM STATUS CATEGORY AND CLAIM STATUS CODE UPDATE ~CMS MLN Matters~

MLN Matters® Number: MM7052
Related CR Release Date: July 16, 2010
Related CR Transmittal #: R2002CP

Related Change Request (CR) #: 7052
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Part A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed

This article, based on CR7052, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the June 2010 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on or about July 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on October 4, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1

and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information

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

The official instruction, (CR7052), issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2002CP.pdf> on the CMS website

EDI ASK-THE-CONTRACTOR TELECONFERENCES (ACTS)

WPS EDI will hold the next Electronic Data Interchange (EDI) Ask-the-Contractor Teleconference (ACT) on September 9, 2010. The EDI ACTs will be for Legacy Part A (institutional providers who joined WPS in October 2007) and Part B (IL, MI, WI, and MN), as well as MAC J5 A and B states (IA, KS, MO, and NE).

WPS EDI will be presenting some information regarding 5010 implementation. You can download or view the presentation at http://www.wpsic.com/edi/med_edi_act.shtml. The EDI ACTs will last one and one-half hours and will address your EDI questions. We encourage providers, billing staff, vendors, and clearinghouses to call with any Medicare EDI questions they deem appropriate.

We will approach the call much in the same way CMS approaches their valuable Open Door Forums, promoting a forum that is less structured, and encourages participants to ask whatever they choose, as long as it pertains to Medicare EDI. We look forward to your participation in these calls!

What are Ask-the-Contractor Teleconferences (ACTs)?

The Medicare Modernization Act (MMA) requires Medicare contractors to hold Ask-the-Contractor Teleconferences (ACTs). This requirement is based on CMS' goal of giving those who provide service to beneficiaries, the information they need to: understand the Medicare program; be informed often and early about changes; and, in the end bill correctly.

The ACT promotes valuable interaction between the Medicare Contractor (WPS) and EDI customers. As stated previously, we modeled our ACTs after CMS Open Door Forums.

Participants are encouraged to ask questions and raise concerns regarding EDI. EDI staff is available during the call to provide education, program updates, answer questions, and take feedback. In addition, we will provide necessary follow-up to any issues that cannot be resolved during the call time.

WPS Medicare encourages providers to participate in this important educational activity. You can access a recording of the EDI ACT teleconference on our website approximately one week following the event.

Please Note: No Registration is Necessary

Course Details

We will conduct our 2010 EDI Ask-the-Contractor Teleconference (ACT) on the dates below. You will need the following information to participate in the call:

Date	Time	Dial-In	ID
September 9, 2010	1 pm CT	800-305-2862	35459366
November 11, 2010	1 pm CT	800-305-2862	35459367

**INTERNET ONLY MANUAL (IOM) CHAPTER 25 REVISIONS
(MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 25 -
COMPLETING AND PROCESSING THE FORM CMS-1450 DATA SET)
~CMS MLN Matters~**

MLN Matters® Number: MM6907
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R1973CP

Related Change Request (CR) #: 6907
Effective Date: September 1, 2010
Implementation Date: September 1, 2010

Provider Types Affected

Hospitals, Home Health Agencies (HHA), hospices, Skilled Nursing Facilities (SNF), and other providers submitting UB-04 claims to Medicare contractors (fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

What You Need to Know

The Medicare Claims Processing Manual, Chapter 25- Completing and Processing the Form CMS-1450 Data Set, is being revised to reference external code sources as is currently done in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Health Care Claim: Institutional (837) Implementation Guide. Providers submitting UB-04s to Medicare may obtain billing codes from the external code sources, the National Uniform Billing Committee (NUBC), or from their Medicare Contractor. The Centers for Medicare & Medicaid Services (CMS) will continue to communicate specific code implementation direction via Change Requests (CRs) as it does today. Specifically, the manual changes are made to include the following language:

- Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC in their official UB-04 Data Specifications Manual available at <http://www.nubc.org> on the Internet.
- Health Insurance Prospective Payment System (HIPPS) Rate Codes/ Modifiers/Assessment Type Indicators and Healthcare Common Procedure Coding System (HCPCS) modifiers used for Medicare claims are available from Medicare contractors.

Additional Information

If you have questions, please contact your Medicare contractor (FI, RHHI or A/B MAC at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website. The official instruction issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1973CP.pdf> on the CMS website.

WILL YOU BE READY TO TEST 5010 IN JANUARY 2011?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates that the healthcare industry use standard formats for electronic claims and claims related transactions. The Secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions on January 16, 2009. The final rule was published and the Health and Human Services Administration issued regulation specifying that updated versions of the standards must be adopted by the industry. Currently, Centers for Medicare and Medicaid Services (CMS), Medicare contractors and standard system maintainers are underway with implementation activities for 5010. Transition to the new formats for Medicare Fee-For-Service (FFS) will start on January 1, 2011, and must be completed by January 1, 2012. Medicare does not anticipate extensions to these deadlines.

The formats currently used must be upgraded from X12 Version 4010A1 to 5010.

- Claim (837-I, 837-P, 837-I COB, 837-P COB, NCPDP) '
- Remittance (835) '
- Claim Status Inquiry/Response (276/277) '
- Eligibility Inquiry/Response (270/271) '
- Claims Acknowledgements (*277CA) '
- Acknowledgement for Health Care Insurance (*999) '

*The 277CA and the 999 are new transactions which will be used for 5010.

It is important to identify the differences between the current 4010A1 formats and the 5010 formats. You, your vendor and/or clearinghouse should perform a 4010A1 to 5010 gap analysis. You should identify: new content, deleted content, modified content and impact to business needs. Communicate and coordinate with your staff as well as your vendor, clearinghouse and payers to insure all impacts are identified early. Know your vendor's schedule. Know your trading partner's schedule. Test both internally and externally.

Transition to the new formats must be completed by January 1, 2012. Medicare does not anticipate extensions to these deadlines. If you rely on your vendor or clearinghouse to maintain your billing system and keep you up-to-date with electronic transactions, you need to ask your vendor and or clearinghouse about their plans for transitioning to the new 5010 format. If you fail to prepare, you may not be able to send electronic claims or receive electronic remittances, significantly impacting your business and cash flow.

If you need additional information, you may also contact the WPS EDI Hotline:

J5 MAC: 866-503-9670 '

Legacy: 866-734-6656 '

General Information**CLARIFICATION ON USE OF THE SKILLED NURSING FACILITY
ADVANCE BENEFICIARY NOTICE (SNFABN) AND DENIAL LETTERS
~CMS MLN Matters~**

MLN Matters® Number: MM6987
Related CR Release Date: June 11, 2010
Related CR Transmittal #: R1983CP

Related Change Request (CR) #: 6987
Effective Date: July 12, 2010
Implementation Date: July 12, 2010

Provider Types Affected

This article is for Skilled Nursing Facilities (SNFs) billing 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) 6987 which clarifies that SNFs may use either the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or Notices of Noncoverage (Denial Letters) for items and services expected to be denied under Medicare Part A. Be sure your billing staff is aware of these changes.

Background

Historically, SNF providers were instructed by Centers for Medicare & Medicaid Services (CMS) to use either the SNFABN (CMS Form 10055) or one of the 5 uniform Denial Letters for items and services expected to be denied under Medicare Part A to fulfill the notification requirements under Section 1879 of the Social Security Act and 42 CFR 411.404. However, the corresponding manual instructions stated that only the SNFABN could be used for this purpose. CR 6987 modifies the Medicare Claims Processing Manual to show that SNFs may use either the SNFABN (CMS Form 10055), which is available at <http://www.cms.gov/BNI/downloads/CMS10055.pdf> or the Denial Letters for items and services expected to be denied under Medicare Part A. The Denial Letters are available at <http://www.cms.gov/BNI/Downloads/SNF%20DENIAL%20LETTERS.pdf> on the CMS website.

Additional Information

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

The official instruction (CR6987) issued to your Medicare A/B MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R1983CP.pdf> on the CMS website.

CLARIFICATION ON USE OF THE SNFABN AND DENIAL LETTERS
 ~CMS Transmittal~

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare Medicaid Services (CMS)
Transmittal 1983	Date: JUNE 11, 2010
	Change Request 6987

SUBJECT: Clarification on Use of the SNFABN and Denial Letters

I. SUMMARY OF CHANGES: This instruction clarifies use of Notices of Noncoverage or Denial Letters by skilled nursing facilities.

EFFECTIVE DATE: July 12, 2010
IMPLEMENTATION DATE: July 12, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
 R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/70/Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
 No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
 The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:**Business Requirements****Manual Instruction**

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1983	Date: June 11, 2010	Change Request: 6987
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SUBJECT: Clarification on Use of the SNFABN and Denial Letters

EFFECTIVE DATE: July 12, 2010

IMPLEMENTATION DATE: July 12, 2010

I. GENERAL INFORMATION**A. Background:**

Historically, SNF providers were instructed by CMS to use either the SNFABN or one of the 5 uniform Denial Letters for items and services expected to be denied under Medicare Part A to fulfill the notification requirements under Section 1879 of the Social Security Act and 42 CFR 411.404. However, the corresponding manual instructions stated that only the SNFABN could be used for this purpose.

This instruction clarifies use of the Skilled Nursing Facility Advance Beneficiary Notice **and** Notices of Noncoverage (Denial Letters) by skilled nursing facilities (SNFs). SNFs may continue using either the SNF Notice of Noncoverage (Denial Letters) or the SNFABN for items and services expected to be denied under Medicare Part A.

B. Policy: The authorizations for these requirements are found in Section 1879 of the Social Security Act as well as 42 CFR 411.404, which specify written notice requirements.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6987.1	Contractors shall accept either the SNFABN (CMS Form 20005) or the SNF Notices of Noncoverage (Denial Letters) as valid notification for items and services expected to be denied under Medicare Part A.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	FI	Carrier	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CBF	
6987.2	Contractors shall review the process associated with the SNFABN as indicated in Chapter 30.	X		X							
6987.3	Contractors shall perform additional individual provider education if alerted that a notifier is not complying with these instructions.	X		X							
6987.4	Contractors shall post this entire instruction, or a direct link to this instruction, on their website and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: N/A

Section B: N/A

V. CONTACTS

Pre-Implementation Contact(s): Charlayne Van, charlayne.van@cms.hhs.gov, 410-786-8659

Post-Implementation Contact(s): Charlayne Van, Charlayne.van@cms.hhs.gov, 410-786-8659

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs):

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**70 - Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
(Rev. 1983, Issued: June 11, 2010; Effective/Implementation Dates: July 12, 2010)**

The following are the standards for use by Skilled Nursing Facilities (SNFs) in implementing the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, model Form CMS-10055) notice of noncoverage requirements. This section provides instructions, consistent with the skilled nursing facility prospective payment process (SNF PPS), regarding the notice that SNFs must provide to beneficiaries in advance of furnishing what SNFs, utilization review (UR) entities, quality improvement organizations (QIOs), or Medicare contractors believe to be noncovered extended care services, or items or of reducing or terminating ongoing covered extended care services or items.

SNFs may continue using either the SNFABN or the SNF Notices of Noncoverage (Denial Letters) to fulfill the notification requirements under Section 1879 of the Social Security Act. When completing and delivering the SNFABN, SNFs must meet the notice standards in §70.3 of Chapter 30 of the Medicare Claims Processing Manual.

SNFs must also meet the ABN Standards in H§40.3H of the Medicare Claims Processing Manual in completing and delivering SNFABNs.

CLINICAL REVIEW JUDGMENT

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6954 Revised
Related CR Release Date: May 14, 2010
Related CR Transmittal #: R338PI

Related Change Request (CR) #: 6954
Effective Date: April 23, 2010
Implementation Date: June 15, 2010

Note: This article was revised on June 16, 2010, to include an additional reference to Chapter 3 of the Medicare Program Integrity Manual on page 2. All other information remains the same.

Provider Types Affected

This impacts all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language regarding clinical review judgments; and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background

Medicare claim review contractors (Carriers, Fiscal Intermediaries (called affiliated contractors, or ACs), Medicare Administrative Contractor (MACs), the Comprehensive Error Rate Testing (CERT) contractor, and Recovery Audit Contractors (RACs)), along with Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC) are

tasked with measuring, detecting and correcting improper payments in the Fee for Service (FFS) Medicare Program.

CR 6954, from which this article is taken, updates the *Medicare Program Integrity Manual* by adding a new Section (3.14 -- Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

NOTE: *Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).*

Additional Information

You can find more information about clinical review judgment by going to CR 6954, located at <http://www.cms.gov/Transmittals/downloads/R338PI.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 14 (Clinical Review Judgment) as an attachment to that CR. The original Chapter 3, which contains more information on CMS' medical review processes, is available at <http://www.cms.gov/manuals/downloads/pim83c03.pdf> on the CMS website.

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

**COMMON WORKING FILE (CWF) UNSOLICITED RESPONSE
ADJUSTMENTS FOR CERTAIN CLAIMS DENIED DUE TO AN OPEN
MEDICARE SECONDARY PAYER (MSP) GROUP HEALTH PLAN
(GHP) RECORD WHERE THE GHP RECORD WAS SUBSEQUENTLY
DELETED OR TERMINATED**

~CMS MLN Matters~

MLN Matters® Number: MM6625
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R2014CP

Related Change Request (CR) #: 6625
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

What You Need to Know

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACs, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

- 1) Reopen certain MSP claims when certain MSP records are deleted, or
- 2) Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare Secondary Payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some

claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional Information

You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2014CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

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

QUARTERLY PROVIDER UPDATE

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare, including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program; '
- Assist providers in understanding CMS programs and complying with Medicare ' regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at <http://www.cms.gov/QuarterlyProviderUpdates/>.

We encourage you to bookmark this website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Listserv (electronic mailing list) at http://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_460.

Provider Education**TRAINING PROGRAMS**

If you are a Legacy Part A provider in the United States who previously contracted with Mutual of Omaha and joined WPS in November 2007, please visit the WPS Medicare Education Schedule at http://www.wpsmedicare.com/part_a/education/seminars.shtml and http://www.wpsmedicare.com/part_a/education/teleconferences.shtml to learn more about and to register for the training programs we have scheduled in the upcoming months.

Some training programs we will be offering for Legacy Part A providers include:

- Inpatient Hospital Prospective Payment System (IPPS) Seminar
- Medicare Secondary Payer (MSP) Billing Seminar
- Skilled Nursing Facility (SNF) Billing Seminar
- Legacy Providers New and Significantly Revised Local Coverage Determinations (LCDs) Teleconference
- Medicare Secondary Payer (MSP) Ask-the-Contractor Teleconference (ACT)

If you are a Jurisdiction 5 (J5) Medicare Administrative Contractor (MAC) Part A provider in Iowa, Kansas, Missouri, and/or Nebraska, please visit the WPS Medicare Education Schedule at http://www.wpsmedicare.com/j5macparta/training/training_programs/ to learn more about and to register for the educational events we have scheduled in the upcoming months.

Some training programs we will be offering for J5 MAC Part A providers include:

- Skilled Nursing Facility (SNF) Billing Seminar '
- J5 MAC New and Significantly Revised Local Coverage Determinations (LCDs) ' Teleconference '
- Medicare Secondary Payer (MSP) Ask-the-Contractor Teleconference (ACT) '
- Skilled Nursing Facility (SNF) Benefits Exhaust & No Pay Teleconference '
- Using C-SNAP Webinar '

Reimbursement**CLAIM ADJUSTMENT REASON CODE (CARC), REMITTANCE ADVICE
REMARK CODE (RARC), AND MEDICARE REMIT EASY PRINT
(MREP) UPDATE
~CMS MLN Matters~**

MLN Matters® Number: MM7089
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2019CP

Related Change Request (CR) #: 7089
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

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

CR 7089, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2010 for Medicare. These are the changes that have been added since CR 6901. Be sure billing staff are aware of these changes.

Background

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 3 times a year – in early March, July, and November although the Committee meets every month.

The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee, and used by all payers. This committee meets 3 times a year, and this code list also gets updated 3 times a year – in early March, July and November. Both code lists are posted at <http://www.wpc-edi.com/Codes> on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 7089.

Additional Information

To see the official instruction (CR7089) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to <http://www.cms.gov/Transmittals/downloads/R2019CP.pdf> on the CMS website.

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

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
235	Sales Tax.	6/6/2010

Modified Codes - CARC

None

Deactivated Codes - CARC

None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.	NO
N534	This is an individual policy, the employer does not participate in plan sponsorship.	NO
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.	YES
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.	NO
N537	We have examined claims history and no records of the services have been found.	NO
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	NO
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	NO

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at http://www.cms.gov .	YES
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD.	YES

Code	Modified Narrative	Medicare Initiated
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp . If you do not have web access, you may contact the contractor to request a copy of the NCD.	YES
N528	Patient is entitled to benefits for Institutional Services only.	NO
N529	Patient is entitled to benefits for Professional Services only.	NO
N530	Not Qualified for Recovery based on enrollment information.	NO

Deactivated Codes – RARC

Code	Current Narrative	Note
M118	Letter to follow containing further information.	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Consider using N130

EXTENSION FOR THE TWO PERCENT AND THREE PERCENT ADD-ON FOR THE GROUND AMBULANCE, AIR AMBULANCE IN RURAL AREAS AND "SUPER RURAL" ADD-ON THROUGH DECEMBER 31, 2010

~CMS MLN Matters~

MLN Matters® Number: MM6972
 Related CR Release Date: May 21, 2010
 Related CR Transmittal #: R706OTN

Related Change Request (CR) #: 6972
 Effective Date: January 1, 2010
 Implementation Date: July 6, 2010

Provider Types Affected

Ambulance providers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), carriers and Medicare Administrative Contractors (MAC)) for ambulance services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 6972, which instructs Medicare contractors to adjust the ambulance fee schedule amounts for ground and air ambulance services for claims with dates of service on or after January 1, 2010, through December 31, 2010.

Any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, should be treated as a rural area for purposes of making payments under the ambulance fee schedule

for air ambulance services furnished during the period beginning January 1, 2010, and ending on December 31, 2010. Please ensure that your staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 amended the Social Security Act with section 1834(l) (13) (A). This section provided increases in payment rates for covered ground ambulance transports which originated in a rural area in the amount of two (2) percent, and for covered ground ambulance transports which originated in a non-rural area by one (1) percent. This provision was effective for the period July 1, 2004 to January 1, 2007.

Section 146(a) of Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by three percent and for covered ground ambulance transports which originated in urban areas by two percent. These increases were only applicable for claims with dates of service July 1, 2008 through December 31, 2009; however, sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act of 2010 (PPACA) reinstate these provisions on or after January 1, 2010 and before January 1, 2011.

Further, section 146(b) (1) of MIPAA amended the designation of rural areas for air ambulance services. The statute specified that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services should continue to be treated as a rural area for purposes of making air ambulance service payments under the ambulance fee schedule. This statute was also applicable for claims with dates of service July 1, 2008 through December 31, 2009; however, sections 3105(b) and 10311(b) of the PPACA further amends section 146(b) (1) of MIPAA to reinstate these provisions for claims with dates of service on or after January 1, 2010 and ending December 31, 2010. Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, the Centers for Medicare & Medicaid Services (CMS) has re-established the "rural" indicator on the zip code file for air ambulance services, effective January 1, 2010.

In addition, section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) specified that, for services furnished during the period July 1, 2004, through December 31, 2009, the payment amount for the ground ambulance base rate was increased where the ambulance transport originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Approximately half of all rural areas (rural counties plus Goldsmith areas) were required to include 25 percent of the rural population arrayed in order of population density. The amount of this increase was based on the Department of Health and Human Services Secretary's estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile of population arrayed by density. CMS determined that the amount of this increase was equal to 22.6 percent. Sections 3105(c) and 10311(c) of ACA further amend section 1834(l) (12) (A) of the Social Security Act to reinstate this provision for claims with dates of service on or after January 1, 2010 and before January 1, 2011, using the percentage increase that was applicable under this provision to ambulance services during 2009.

Additional Information

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

The official instruction issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R706OTN.pdf> on the CMS website.

**INPATIENT REHABILITATION FACILITY (IRF) ANNUAL UPDATE:
PROSPECTIVE PAYMENT SYSTEM (PPS) PRICER CHANGES FOR
FISCAL YEAR (FY) 2011
~CMS MLN Matters~**

MLN Matters® Number: MM7076
Related CR Release Date: August 13, 2010
Related CR Transmittal #: R2026CP

Related Change Request (CR) #: 7076
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for IRFs 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) 7076 which provides updated rates used to correctly pay IRF PPS claims for FY 2011. Be sure your billing staff is aware of these changes.

Background

On August 7, 2001, the Centers for Medicare & Medicaid services (CMS) published in the Federal Register, a final rule that established the PPS for IRFs, as authorized under Section 1886(j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge Federal rates for Federal FY 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section 1886(j)(3)(C) of the Act.

The FY 2011 IRF PPS Update Notice published on July 22, 2010, sets forth the prospective payment rates applicable for IRFs for FY 2011. A new IRF PRICER software package will be released prior to October 1, 2010 that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2010 through September 30, 2011.

PRICER Updates: For IRF PPS FY 2011 (October 1, 2010 – September 30, 2011)

- The standard Federal rate is \$13,860;
- The fixed loss amount is \$11,410;
- The labor-related share is 0.75271;
- The non-labor related share is 0.24729;
- Urban national average Cost-to-Charge Ratio (CCR) is 0.489;

- & Rural national average CCR is 0.620;
- & The Low Income Patient (LIP) Adjustment is 0.4613, which represents no change from FY 2010;
- & The Teaching Adjustment is 0.6876, which is no change from FY 2010; and
- & The Rural Adjustment is 1.1840, which is also the same as FY2010.

Note also that for atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit Health Insurance PPS (HIPPS) Rate/ Case-Mix Group (CMG) Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, CMS instructs IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001).

Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR7076) issued to your Medicare MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R2026CP.pdf> on the CMS website.

JULY QUARTERLY UPDATE FOR 2010 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS) FEE SCHEDULE ~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6945 Revised
Related CR Release Date: July 1, 2010

Related Change Request (CR) #: 6945
Effective Date: January 1, 2010 for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010 for the revisions to the RA & RB modifier descriptors which became effective April 1, 2010; July 1, 2010 for all other changes
Implementation Date: July 6, 2010

Related CR Transmittal #: R1993CP

Note: This article was revised on July 1, 2010, to reflect changes made by the release of an updated Change Request (CR) 6954. Language on page 2 in bold was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 will be adjusted if brought to the contractor's attention. In addition, the Transmittal number, CR release date, and web address for the CR has been changed. All other material remains the same.

Provider Types Affected

This article is for providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

Key Points of CR6945

- & Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 with dates of service on or after January 1, 2010 that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.**
- & CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code - A4221 Supplies for Maintenance of Drug Infusion Catheter, Per Week. To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.
- & CR6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items. Additionally, the descriptors for RA and RB are being revised, effective April 1, 2010, to read as follows:
 - o RA - Replacement of a DME, Orthotic or Prosthetic Item

- &RB - Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair

Suppliers should continue to use the RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. Likewise, the RB modifier should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device.)

- & Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is 5 years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than 5 years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to 3 months.
- & HCPCS code Q0506 Battery, Lithium-Ion, For Use With Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium ion – HCPCS codes Q0496 and Q0503 – remains at 6 months as described in CR3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, Orthotic or Prosthetic Item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR6945) issued to your Medicare DME MAC may be found at <http://www.cms.gov/transmittals/downloads/R1993CP.pdf> on the CMS website.

**MEDICARE PART A SKILLED NURSING FACILITY (SNF)
PROSPECTIVE PAYMENT SYSTEM (PPS) PRICER UPDATE FY 2011
~CMS MLN Matters~**

MLN Matters® Number: MM7034
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2023CP

Related Change Request (CR) #: 7034
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for SNFs billing Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services paid under the SNF PPS.

Provider Action Needed

This article is based on Change Request (CR) 7034 which describes the updates to the payment rates used under the PPS for SNFs, for FY 2011, as required by statute. Be sure your billing staff is aware of these changes.

Background

Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (the BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for FY 2011 (that is, beginning October 1, 2010 through September 30, 2011), in the Federal Register on July 22, 2010 (75 FR 42886). The updated methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with acquired immunodeficiency syndrome (AIDS). This update includes new case-mix indexes using the recalculated case-mix adjustments based on actual data. The statute mandates an update to the Federal rates using the latest SNF full market basket.

The enactment of the Affordable Care Act (ACA) includes several provisions that affect the SNF PPS. CMS is currently finalizing a strategy for completing the complex infrastructure changes necessary to accurately implement these changes. CMS has concluded that the best way to minimize risk will be to establish an interim payments mechanism that utilizes the MDS 3.0 and the new RUG-IV system in its entirety as finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009). The Pricer software update issued to CMS contractors reflects this interim payment approach. Once the necessary infrastructure is in place, CMS will then issue a revised Pricer program and instructions to contractors to retroactively adjust claims to reflect the applicable provisions of the ACA.

This approach will allow CMS to make payments with the least disruption for providers and beneficiaries. CMS will publish the specific payment rates for the upcoming fiscal year in the Federal Register, and provide additional guidance concerning implementation of the FY 2011 payments in the near future.

Additional Information

MLN Matters® article, MM6916, contains information on new and deleted HIPPS codes resulting from the conversion to the new RUG-IV coding system. The new 5-digit HIPPS codes include two components: the 3-digit classification code assigned to each RUG group, and newly defined 2-digit assessment indicators that specify the type of assessment used to support billing. You can review this article at

<http://www.cms.gov/MLNMattersArticles/downloads/MM6916.pdf> on the CMS website.

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR7034) issued to your Medicare A/B MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R2023CP.pdf> on the CMS website.

**OCTOBER 2010 QUARTERLY AVERAGE SALES PRICE (ASP)
MEDICARE PART B DRUG PRICING FILES AND REVISIONS TO
PRIOR QUARTERLY PRICING FILES
~CMS MLN Matters~**

MLN Matters® Number: MM7007
Related CR Release Date: June 18, 2010
Related CR Transmittal #: R1990CP

Related Change Request (CR) #: 7007
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article is for all physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010 and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

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

Files	Effective Dates of Service
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009

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

Additional Information

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

The official instruction (CR7007) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.gov/Transmittals/downloads/R1990CP.pdf> on the CMS website.

OCTOBER QUARTERLY UPDATE FOR 2010 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS) FEE SCHEDULE ~CMS MLN Matters~

MLN Matters® Number: MM7070
Related CR Release Date: July 23, 2010

Related Change Request (CR) #: 7070
Effective Date: January 1, 2010 for codes in
effect then, October 1, 2010 for other changes
Implementation Date: October 4, 2010

Related CR Transmittal #: R2006CP

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed

This article is based on CR 7070, which provides the required quarterly update of the 2010 DMEPOS Fee Schedule. Be sure billing staffs are aware of the update.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the Medicare Claims Processing Manual, Chapter 23, Section 60 at <https://www.cms.gov/manuals/downloads/clm104c23.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key Points of CR7070

- & Per Transmittal 686 (Change Request 6743), the claims filing jurisdiction for HCPCS code L8509 (*Tracheo-Esophageal Voice Prosthesis, Inserted by a Licensed Health Care Provider, Any Type*) is changing from the DME MACs to the A/B MACs/Part B carriers, **effective October 1, 2010**. To reflect this change, the claims jurisdiction for code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.
- & As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (*Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each*) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors **will adjust previously processed claims for code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments**.

Additional Information

The official instruction, CR 7070, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2006CP.pdf> on the CMS website.

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

An earlier MLN Matters® article, MM6743 on the *Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prosthesis Healthcare Common Procedure Coding System (HCPCS) Code* may be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM6743.pdf> on the CMS website.

**REVISED PAYMENT FILES FOR THE 2010 MEDICARE PHYSICIAN
FEE SCHEDULE DATABASE (MPFSDB) AND RETROACTIVE
PROVISIONS UNDER THE PATIENT PROTECTION AND
AFFORDABLE CARE ACT (PUB. L. 111-148) (THE AFFORDABLE
CARE ACT)**

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6973 Revised
Related CR Release Date: May 10, 2010
Related CR Transmittal #: R700OTN

Related Change Request (CR) #: 6973
Effective Date: January 1, 2010
Implementation Date: No later than June 1, 2010

Note: This article was revised on May 24, 2010, to show that Medicare's implementation date for using the new payment files is no later than June 1, 2010. All other information remains the same.

Provider Types Affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS) are affected by this article.

Provider Action Needed

This article is based on Change Request (CR) 6973, which amends payment files that were issued to contractors to take into account the 2010 MPFS Final Rule correction notice that went on display at the Federal Register on May 5, 2010 and retroactive provisions under the Affordable Care Act.

Background

Payment files were issued to contractors based on the calendar year (CY) 2010 MPFS Final Rule. Subsequent to the publication of the CY 2010 MPFS Final Rule:

- The Department of Defense Appropriations Act of 2010 provided a two month zero percent update to the 2010 MPFS, effective for dates of service January 1, 2010, through February 28, 2010;
- The Temporary Extension Act of 2010 extended the zero percent update to the 2010 MPFS for dates of service through March 31 2010; and
- The Continuing Extension Act of 2010 extended the zero percent update to the 2010 MPFS for dates of service through May 31, 2010.

CR6973 includes changes as a result practice expense (PE) and malpractice (MP) relative value unit (RVU) corrections and provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act), as modified by the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 23, 2010, and March 30, 2010, respectively.

The PE and MP RVUs have been revised to align their values with the final CY 2010 MPFS policies for PE and MP RVUs. Although the zero percent (0%) update to the 2010 MPFS has been extended through legislation, the conversion factor (CF) has been revised as a

result of the PE and MP RVU corrections. The revised CF used in calculating the payment amounts associated with this instruction is \$36.0791.

The Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, also included the extension of several provisions, retroactive to January 1, 2010, that had previously been included in other legislation. The extended provisions include 1) the extension of the work geographic practice cost index (GPCI) floor of 1.0 through December 31, 2010; 2) the extension of the MPFS mental health add-on 3) the extension of the exceptions process for Medicare therapy caps; and 4) the extension of payment for the technical component (TC) of certain physician pathology services. Also included is a revision to the PE GPCIs for CY 2010 and a new provision regarding payment for bone density tests in CY 2010.

Descriptions of Provisions

Revisions to CY 2010 Work and PE GPCIs

Section 3102 of the Affordable Care Act extends the 1.0 work GPCI floor for services furnished through December 31, 2010. It also revises the PE GPCIs for CY 2010 so that the employee wage and rent portions of the PE GPCI reflect only one-half of the relative cost differences for each locality compared to the national average. Each PFS locality is held harmless under the PE GPCI changes.

These changes are reflected in the revised payment files and are retroactive to January 1, 2010.

Extension of Physician Fee Schedule Mental Health Add-On

Section 138 of the Medicare Improvements for Patients and Providers Act of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extends this provision retroactive to January 1, 2010, through December 31, 2010. The "Psychiatry" CPT codes that represent the "specified services" are as follows:

- **Office or Other Outpatient Facility**
 - (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy) CPT Codes 90804, 90805, 90806, 90807, 90808, 90809
 - (Interactive Psychotherapy) CPT Codes 90810, 90811, 90812, 90813, 90814, 90815
- **Inpatient Hospital, Partial Hospital or Residential Care Facility**
 - (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy) CPT Codes 90816, 90817, 90818, 90819, 90821, 90822
 - (Interactive Psychotherapy) CPT Codes 90823, 90824, 90826, 90827, 90828, 90829

The increased payment amounts for these codes are included on the revised payment files and are retroactive to January 1, 2010.

Payment for Bone Density Tests

Section 3111 of the Affordable Care Act adjusts the payment amounts for bone density tests. For dual-energy x-ray absorptiometry services furnished during CY 2010, the payment amount will be equal to 70 percent of the product of a) the relative value for the service for CY 2006; b) the conversion factor for CY 2006; and c) the CY 2010

geographic adjustment factor for the service for the fee schedule area (payment locality). In CY2011, part (c) of the formula will use the CY 2011 geographic adjustment factor.

These services were identified in 2006 by CPT codes 76075 and 76077, but have since been renumbered to 77080 and 77082. Based on this provision, the adjusted RVUs for these services are shown in the following table.

CPT MOD	WRVU	NON-FACILITY PE RVU	FACILITY PE RVU	MAL-PRACTICE RVU	NON-FACILITY TOTAL	FACILITY TOTAL
77080		0.22	2.35 NA		0.13	2.70 NA
	26	0.22	0.07 0.07 0.01			0.30 0.30
	TC	0.00	2.28 NA		0.12	2.40 NA
77082		0.12	0.59 NA		0.05	0.76 NA
	26	0.12	0.04 0.04 0.01			0.17 0.17
	TC	0.00	0.55 NA		0.04	0.59 NA

The adjusted payment amounts for these codes are included on the revised payment files and are retroactive to January 1, 2010.

Extension of Exceptions Process for Medicare Therapy Caps

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continues the exceptions process through December 31, 2010.

Extension of Payment for the TC of Certain Physician Pathology Services

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a Medicare Administrative Contractor (MAC) for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extends the payment for the TC of certain physician pathology services retroactive to January 1, 2010, through December 31, 2010.

Additional Information

The official instruction (CR 6973) issued to your carrier, FI, RHHI or A/B MAC, regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R700OTN.pdf> on the CMS website.

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

**UPDATE-INPATIENT PSYCHIATRIC FACILITIES PROSPECTIVE
PAYMENT SYSTEM (IPF PPS) RATE YEAR 2011
~CMS MLN Matters~**

MLN Matters® Number: MM6986
Related CR Release Date: June 4, 2010
Related CR Transmittal #: R1981CP

Related Change Request (CR) #: 6986
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected

Providers submitting claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the IPF PPS are affected.

Provider Action Needed

This article is based on Change Request (CR) 6986 which identifies changes that are required as part of the annual Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) update from the Rate Year (RY) 2011 IPF PPS update notice, published on April 30, 2010. These changes are applicable to IPF discharges occurring during the rate year July 1, 2010 through June 30, 2011, and this is the fifth RY update to the IPF PPS. The applicable previous year update is detailed in MLN Matters® article MM6461 and may be reviewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6461.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. Make sure that your billing staff are aware of these IPF PPS changes.

Background

Payments to IPFs under the IPF PPS are based on a Federal Per Diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually. The RY update is effective July 1 - June 30, and the Medicare Severity Diagnosis Related Groups (MS-DRGs) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

Change Request (CR) 6986 identifies changes that are required as part of the annual IPF PPS update from the RY 2011 IPF PPS update notice, published on April 30, 2010. These changes are applicable to IPF discharges occurring during the rate year July 1, 2010 through June 30, 2011.

Market Basket Update

CMS is required to apply an "Other Adjustment" that reduces any update to the IPF PPS base rate by 0.25 percentage point for the rate year beginning in 2010, and CR 6986 implements this requirement for RY 2011. See the Social Security Act (Section 1886(s)(3)(A); http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet), which was added by:

- The Affordable Care Act (Pub. L. 111-148; Sections 3401(f) amended by Section 10319(e); http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf on the Internet); and

- & The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152; Section 1105; <http://www.gpo.gov/fdsys/pkg/BILLS-111hr4872EH/pdf/BILLS-111hr4872EH.pdf> on the Internet).

Note: CR 6986 reduces the update to the IPF PPS base rate by 0.25 percent (0.25%) for rate year 2011.

Starting with the RY 2010 Federal per diem base rate of \$651.76 and applying the market basket increase of 2.4 percent, with the “Other Adjustment” of -0.25%, and the wage index budget neutrality factor of 0.9999 yields a **Federal per diem base rate of \$665.71 for RY 2011.**

Similarly, applying the market basket increase with the “Other Adjustment,” and the wage index budget neutrality factor to the RY 2010 electroconvulsive therapy (ECT) rate yields an **ECT rate of \$286.60 for RY 2011.**

PRICER Updates

For IPF PPS RY 2011, the following are effective for discharges on July 1, 2010 through June 30, 2011:

- The Federal per diem base rate is \$665.71.
- The fixed dollar loss threshold amount is \$6,372.00.
- The IPF PPS will use the FY 2010 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 75.400 percent.
- The non-labor related share is 24.600 percent.
- The ECT rate is \$286.60.

Cost to Charge Ratios

The National Urban and Rural Cost to Charge Ratios (CCR) for the IPF PPS RY 2011 are displayed in the following table:

Cost to Charge Ratio	Median	Ceiling
Urban	0.5170	1.7377
Rural	0.6480	1.7383

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

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the Medicare FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG Update

The code set and adjustment factors are unchanged for RY 2011.

Additional Information

Note: For the FY 2010 pre-floor, pre-reclassified hospital wage index, CMS is using the updated wage index and the wage index budget neutrality factor of 0.9999.

The official instruction, CR 6986, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1981CP.pdf> on the CMS website.

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

UPDATE TO HOSPICE PAYMENT RATES, HOSPICE CAP, HOSPICE WAGE INDEX AND THE HOSPICE PRICER FOR FISCAL YEAR (FY) 2011

~CMS MLN Matters~

MLN Matters® Number: MM7077
Related CR Release Date: July 23, 2010
Related CR Transmittal #: R2004CP

Related Change Request (CR) #: 7077
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

Hospice providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries need to be aware of this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7077 which provides the annual update to the hospice payment rates for fiscal year FY 2011, the hospice aggregate cap amount for the cap period ending October 31, 2010, and the hospice wage index and Pricer for FY 2011. Be sure your billing staffs are aware of these changes, which are described in the Background section, below.

Background

CMS updates the payment for hospice care, the hospice aggregate cap amount, and the hospice wage index annually. The Social Security Act (the Act) (Section 1814(i)(1)(C)(ii)) stipulates that the **payments for hospice care** for fiscal years after 2002 will increase by the market basket percentage increase for that fiscal year (FY), and this payment methodology is codified in the Code of Federal Regulations (refer to Title 42, Section 418.306 (a)&(b)).

FY 2011 Hospice Payment Rates

The FY 2011 payment rates will be the FY 2010 payment rates, increased by 2.6 percentage points, which is the total hospital market basket percentage increase forecasted for FY 2011. The FY 2011 hospice payment rates are shown in the following table and are effective for care and services furnished on or after October 1, 2010 through September 30, 2011.

Code	Description	Rate	Wage Component Subject to Index	Non-Weighted Amount
651	Routine Home Care	\$146.63	\$100.75	\$ 45.88
652	Continuous Home Care Full Rate = 24 hours of care \$35.66= hourly rate	\$855.79	\$588.01	\$267.78
655	Inpatient Respite Care	\$151.67	\$ 82.10	\$ 69.57
656	General Inpatient Care	\$652.27	\$417.52	\$234.75

Reference to the hospice payment rate is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.2 (Payment Rates); see <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf> on the CMS website.

Hospice Cap

The latest hospice cap amount for the cap year ending October 31, 2010 is **\$23,874.98**. In computing the cap, CMS used the medical care expenditure category of the March 2010 Consumer Price Index for all Urban consumers, published by the Bureau of Labor Statistics, (see <http://www.bls.gov/cpi/home.htm> on the Internet), which was 387.142. The hospice cap is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 80.2 (Cap on Overall Hospice Reimbursement); see <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf> on the CMS website).

Hospice Wage Index

The Hospice Wage Index notice with comment period will be effective October 1, 2010 and published in the **Federal Register** before that date. The revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the wage index final rule.

Additional Information

You can find the official instruction, CR7077, issued to your FI, A/B MAC, or RHHI by visiting <http://www.cms.gov/Transmittals/downloads/R2004CP.pdf> on the CMS website.

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

UPDATES TO THE INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS), LONG TERM CARE HOSPITAL (LTCH) PPS, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS), AND INPATIENT REHABILITATION FACILITY (IRF) PPS CHANGES DUE TO THE AFFORDABLE CARE ACT (ACA)

~CMS MLN Matters~

MLN Matters® Number: MM7029
Related CR Release Date: July 15, 2010
Related CR Transmittal #: R728OTN

Related Change Request (CR) #: 7029
Effective Date: Various as indicated in article
Implementation Date: August 9, 2010

Provider Types Affected

This article is for hospitals, LTCHs, IRFs, and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services paid under one of the subject prospective payment systems.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7029 which outlines changes for IPPS hospitals for Federal FY 2010, LTCHs for RY2010, IRFs for FY 2010, and OPPS for CY 2010 as a result of the Affordable Care Act (ACA).

CAUTION – What You Need to Know

The policy changes reflected in CR 7029 will appear in upcoming Federal Register notices for the IPPS/LTCH PPS, OPPS and IRF PPS. The changes in CR 7029 have various retroactive effective dates, and Medicare Contractors will be instructed in a CR on how to handle past claims paid under pre-ACA requirements. Once that CR is released, a related article will be available on the Centers for Medicare & Medicaid Services (CMS) website.

GO – What You Need to Do

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

Background

Several of the provisions of the Affordable Care Act (ACA) affect the Fiscal Year (FY) 2010 Inpatient Prospective Payment System (IPPS), the Rate Year (RY) 2010 Long Term Care Hospitals Prospective Payment System (LTCH PPS), and the Calendar Year (CY) 2011 Outpatient Prospective Payment System (OPPS). In particular, certain provisions require changes to the wage index and market basket update and, as a result, changes to area wage indices (including the statewide rural floor budget neutrality adjustments under the IPPS and OPPS), rates, and outlier thresholds for these provider payment systems.

Change Request (CR) 7029 outlines changes (as a result of the ACA) as follows.

IPPS Updates***Extension of Section 508 Reclassifications and Special Exceptions Wage Indices and Changes to the FY 2010 IPPS Wage Index***

Sections 3137(a) and 10317 of the Affordable Care Act retroactively extend section 508 reclassifications and special exceptions wage indices through September 30, 2010 (that is, for discharges occurring on or after October 1, 2009, through discharges on or before September 30, 2010). Effective April 1, 2010, section 10317 also requires removing section 508 and special exceptions hospitals' wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. As a result of these changes to the wage index (and the changes to the market basket update as discussed below), many of the originally published FY 2010 IPPS wage indices (including the statewide rural floor budget neutrality adjustment factors) have changed for either all of FY 2010 (for section 508 and special exceptions hospitals) or for only the second half of FY 2010 (for all other IPPS hospitals).

All section 508 and special exceptions hospitals affected by sections 3137(a) and 10317 will be assigned an individual special wage index effective October 1, 2009. A section 508 or special exceptions hospital shall be assigned, for the entire FY 2010, the higher of its wage index value from the FY 2010 IPPS final rule (74 FR 44032-44078, August 27, 2009) and correction notice (74 FR 51496-51507, October 7, 2009), or its wage index value under the revised FY 2010 wage index values effective April 1, 2010.

Attachment A of CR 7029 (the CR is available at <http://www.cms.gov/Transmittals/downloads/R728OTN.pdf> on the CMS website) shows the wage indices for the section 508 or special exceptions hospitals paid under the IPPS for discharges on or after October 1, 2009, through discharges on or before September 30, 2010.

For all other IPPS providers not listed in Attachment A of CR 7029, the revised FY 2010 wage indices (including the revised statewide rural floor budget neutrality adjustment factors) resulting from the implementation of sections 3137 and 10317 of the ACA (and the change in the market basket update as discussed below) are effective only for discharges occurring on or after April 1, 2010 and on or before September 30, 2010. The revised FY 2010 IPPS wage indices discussed above for section 508/special exceptions hospitals and all other IPPS hospitals are included in the latest version of Pricer. Updated IPPS wage index tables reflecting the revised wage indices that are effective April 1, 2010 through September 30, 2010 (Table 2 – providers' case mix indices, wage indices, and average hourly wages; Tables 4A, 4B, and 4C – urban, rural, and reclassified area wage indices; and Table 4D-1 – statewide rural floor budget neutrality factors) can be downloaded from the CMS website at <http://www.cms.gov/AcuteInpatientPPS/WIFN/itemdetail.asp?filterType=nonefilterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1234175&intNumPerPage=10> on the CMS website.

The following lists the IPPS providers with Medicare Geographic Classification Review Board (MGCRB) reclassifications and their revised wage index values for the second half of FY 2010 (April 1, 2010 – September 30, 2010):

Provider #	Special Wage index effective 4/1/10-9/30/10
070015	1.2695
070033	1.2695

Provider #	Special Wage index effective 4/1/10-9/30/10
310002	1.2769
310009	1.2769
310015	1.2769
310017	1.2769
310018	1.2769
310038	1.2769
310039	1.2769
310054	1.2769
310070	1.2769
310076	1.2769
310083	1.2769
310093	1.2769
310096	1.2769
310108	1.2769
310119	1.2769
330027	1.2930
330167	1.2930
330181	1.2930
330182	1.2930
330198	1.2930
330225	1.2930
330259	1.2930
330331	1.2930
330332	1.2930
330372	1.2930

All of the hospitals listed within this section are reclassified under Section 508 of the MMA or reclassified through the MGCRB.

Market Basket Update Reduction for IPPS

Section 3401(a) of the ACA imposes a 0.25 percentage point reduction to the IPPS market basket update for FY 2010 that is applied to the operating standardized amounts and hospital-specific rates for Sole Community Hospitals and Medicare Dependant Hospitals. This law also specified that the revised FY 2010 rates only apply to payments made for discharges occurring on or after April 1, 2010. As a result of this provision, CMS updated the IPPS standardized amounts, budget neutrality factors and outlier threshold to be applied in making payments for discharges on or after April 1, 2010 through discharges occurring on or before September 30, 2010, the second half of FY 2010. CMS notes that as a result of implementing these provisions of the ACA, for Sole Community Hospitals and Medicare Dependant Hospitals, for discharges on or after April 1, 2010 through discharges on or before September 30, 2010, the Pricer will apply the revised diagnostic related group (DRG) Reclassification and Recalibration Budget Neutrality Factor of 0.997935 to the hospital specific rate (see the "FY 2010 IPPS Rates" table below). (For Sole Community Hospitals and Medicare Dependant Hospitals, for discharges on or after October 1, 2009 through discharges on or before March 30, 2010, the DRG Reclassification and Recalibration Budget Neutrality Factor of 0.997941 is

applied to the hospital specific rate.) The updated FY 2010 IPPS rates, budget neutrality factors and outlier thresholds are listed in the tables below.

FY 2010 IPPS Rates (Effective for Discharges on or after April 1, 2010 through discharges on or before September 30, 2010)

National Standardized Amounts Update Factor	1.0185 0.9985 (for hospitals that do not submit quality data)
Puerto Rico Specific Standardized Amounts Update Factor	1.021 1.021 (for hospitals that do not submit quality data)
MDH/SCH Hospital Specific Update Factor	1.0185 0.9985 (for hospitals that do not submit quality data)
Outlier Fixed Loss Cost Threshold	\$23,135.00
Federal Capital Rate	\$429.56
Puerto Rico Capital Rate	\$203.57
Outlier Offset-Operating National	0.948998
Outlier Offset-Operating Puerto Rico	0.957417
IME Formula (no change for FY10)	$1.35 \times [(1 + \text{resident to bed ratio}) \cdot 405 - 1]$
DRG Reclassification and Recalibration Budget Neutrality Factor (applied to the Hospital Specific Rate)	0.997935

Operating Rates with FULL Market Basket

	<i>Wage Index > 1</i>		<i>Wage Index ≤ 1</i>	
	Labor Share	Non-Labor Share	Labor Share	Non-Labor Share
National	\$3,587.24	\$1,626.78	\$3,232.69	\$1,981.33
PR National	\$3,587.24	\$1,626.78	\$3,232.69	\$1,981.33
PR Specific	\$1,543.61	\$942.07	\$1,541.12	\$944.56

Operating Rates with REDUCED Market Basket

	<i>Wage Index > 1</i>		<i>Wage Index ≤ 1</i>	
	Labor Share	Non-Labor Share	Labor Share	Non-Labor Share
National	\$3,516.80	\$1,594.84	\$3,169.22	\$1,942.42
PR National	\$3,587.24	\$1,626.78	\$3,232.69	\$1,981.33
PR Specific	\$1,543.61	\$942.07	\$1,541.12	\$944.56

LTCH PPS Updates

Section 3401(c) of the ACA imposes a 0.25 percentage point reduction to the LTCH market basket update for Rate Year (RY) 2010. This law also specified that the revised RY 2010 rates only apply to payments made for discharges on or after April 1, 2010. Therefore, CMS has updated the LTCH standard Federal rate and outlier threshold (shown in the following table) to be applied in making payments for discharges on or after April 1, 2010 through discharges on or before September 30, 2010, the second half of RY 2010.

Federal Rate	\$39,794.95
High Cost Outlier Fixed-Loss Amount	\$18,615.00

In addition, for making payments for the second half of RY 2010, the FY 2010 IPPS rates used to compute the “IPPS comparable amount” in the short-stay outlier (SSO) payment formula have also been updated to reflect the changes to those rates required by the ACA.

OPPS Updates

Section 3401(i) of the Affordable Care Act, as amended by Section 10319 Pub. L. 111-148, imposes a 0.25 percentage point reduction to the Outpatient Prospective Payment System (OPPS) hospital’s market basket for calendar year (CY) 2010, effective for services furnished on or after January 1, 2010. Section 3137 of the Affordable Care Act as amended by Section 10317 extends wage index reclassifications under Section 508 and special exception reclassifications. Hospitals located in a CBSA that includes a section 508 reclassification or special exception reclassification will be paid using a revised wage index beginning April 1 under the IPPS and July 1 under the OPPS.

Further, section 3137 as amended by Section 10317 specifies that if the Section 508 or special exception hospital’s wage index applicable for the period beginning on October 1, 2009, and ending on March 31, 2010, is lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, the hospital shall be paid an additional amount that reflects the difference between the wage indices. The provision applies to both IPPS and OPPS hospital payments.

Instructions about how to handle past claims under pre-ACA requirements are forthcoming. The new post-reclassification wage index values and changes to the hospital operating market basket affect the calculation of the CY 2010 OPPS conversion factor. For the CY 2010 OPPS Final Rule, CMS calculated a final conversion factor of \$67.406 (74 FR 60419). CMS now calculates a revised CY 2010 OPPS conversion factor of \$67.241 by applying the revised wage index adjustment and the updated market basket. For a detailed discussion of the calculation of the conversion factor and the OPPS payment rates, please see the CY 2010 OPPS final rule claims accounting available online at http://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS_1414_FC_OPSS_2010_FR_Claims_Accounting_narrative.pdf on the CMS website and the November 20, 2009 CY 2010 OPPS/ASC final rule with comment period (74 FR 60419).

Due to the revised CY 2010 OPPS conversion factor, the CY 2010 OPPS payment rates for certain services based on the new conversion factor, effective January 1, 2010, will change. Consequently, any calculations based on these revised OPPS payment rates would also change, including the OPPS copayment rates. Offset calculations that are based on payment rates have also changed, including the Drug and Device Offsets available online at http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage and the device FB/FC modifier offsets available online at http://www.cms.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage on the CMS website.

Finally, section 3121 of the ACA extends the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1,

2010 through December 31, 2010 and these providers will receive TOPs payments at 85 percent of the hold harmless amount until December 31, 2010. Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in CY 2010.

Changes to Payments for Certain Drugs and Biologicals

In addition to these changes created by the affordable care act, the copayment for diagnostic radiopharmaceuticals, implantable biologicals and contrast agents with pass-through status was incorrect in the April OPSS Pricer, version 2.0. The copayment amount is now correct in the updated OPSS Pricer, version 2.2.

Changes to OPSS Pricer Logic

- & The OPSS Pricer is revised to reflect the CY 2010 OPSS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by sections 3401 and 3137 of the ACA, respectively, effective for services furnished on and after January 1, 2010. New OPSS payment rates and copayment amounts will be effective for services furnished on and after January 1, 2010.
- & Update unrelated to ACA - The OPSS Pricer is revised to reflect \$0 copayments for the diagnostic radiopharmaceuticals, implantable biologicals and contrast agents with pass-through status beginning January 1, 2010 as the OPSS Pricer, version 2.0, incorrectly included a copayment for those items.
- & Update unrelated to ACA - The OPSS Pricer is revised to reflect correct payment amounts for three Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biological, effective April 1, 2010. The corrected payment rates are listed below and in CR 6996.

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9258	G	9258	Telavancin injection	\$2.12	\$0.42
C9262	G	9262	Fludarabine phosphate, oral, 1 mg	\$8.18	\$1.61
J1540	K	0923	Gamma globulin 9 CC inj	\$141.64	\$28.33

- Effective for services furnished on and after January 1, 2010, all SCHs and EACHs will be eligible for Transitional Outpatient Payments (TOPs) without regard to the bed size of the facility. Effective for services furnished on and after January 1, 2010, small rural hospitals with 100 or fewer beds will be eligible for TOPs. Rural SCH/EACHs will continue to receive a 7.1 percent payment increase for most services in CY 2010. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173.
- Although copayment amounts will change as a result of the recalculation of the CY 2010 OPSS payment rates, all coinsurance rates remain limited to a maximum of 40

- percent of the ambulatory payment classification (APC) payment rate. Copayment amounts for each service continue to be limited to the inpatient deductible of \$1,100.
- & Effective January 1, 2010, CMS is adopting the final FY 2010 IPPS post-reclassification wage index values as revised by section 3137(a) as amended by 10317 of Pub. L. 111-148 for the calendar year, including extension of section 508 reclassification wage index values through September 30, 2010. Special exception wage values apply for CY 2010. Revised post-reclassification wage index values implemented in the IPPS Pricer in April will be implemented in the OPSS in July and issued with the July Pricer. (See CR 6996 at <http://www.cms.gov/Transmittals/downloads/R1980CP.pdf> on the CMS website.)
 - & Effective January 1, 2010 there will be two contrast agents receiving pass-through payments in the OPSS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the “policy-packaged” portions of the CY 2010 APC payments for procedures using contrast agents and may be found on the CMS website. These offset amounts have been updated to reflect CY 2010 OPSS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by sections 3401 and 3137 of the ACA.
 - & Effective January 1, 2010 there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPSS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2010 APC payments for nuclear medicine procedures and may be found on the CMS website. These offset amounts have been updated to reflect CY 2010 OPSS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by sections 3401 and 3137 of the ACA.
 - & APC offset amounts equal to the device portion of the APC for devices received without cost or at a reduced cost, and indicated by the FB and FC modifier respectively, are updated to reflect CY 2010 OPSS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by sections 3401 and 3137 of the ACA.

IRF Updates

Sections 1886(j)(3)(C) and (D) of the Act require the increase factor to be reduced by 0.25 percentage point for FY 2010 and FY 2011. In accordance with paragraph (p) of section 3401 of the ACA, the adjusted FY 2010 market basket increase factor is only applied to discharges on or after April 1, 2010. Thus, CMS revised the FY 2010 IRF Federal prospective payment rates for all IRF discharges occurring on or after April 1, 2010 to reflect an adjusted market basket increase factor of 2.25 percent, instead of the 2.5 percent market basket increase factor for FY 2010 that was published in the FY 2010 IRF PPS final rule (74 FR 39778). Revising the market basket increase factor for FY 2010 from 2.5 percent to 2.25

percent changes the FY 2010 standard payment conversion factor from the \$13,661 that was published in the FY 2010 IRF PPS final rule (74 FR 39780) to \$13,627.

In order to maintain estimated outlier payments in FY 2010 at the percentage adopted in the CMS FY 2010 final rule, CMS revises the IRF outlier threshold amount for FY 2010 from \$10,652 that was published in the FY 2010 IRF PPS final rule (74 FR 39788) to \$10,721 for FY 2010 IRF discharges occurring on or after April 1, 2010. The outlier threshold amount of \$10,652 continues to apply for IRF discharges occurring on or after October 1, 2009 through March 31, 2010.

Additional Information

The official instruction, CR 7029, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R728OTN.pdf> on the CMS website.

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

WPS MEDICARE PROVIDER SERVICES

For additional information on the content of this newsletter, changes in policy or procedures, how to obtain a hardcopy of a Local Coverage Determination (LCD), or if you experience difficulties obtaining a policy on our website, please contact a customer service representative at the telephone numbers/addresses listed below.

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