

Communiqué

Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Items of Importance**ALL PROVIDERS ARE EXPECTED TO SUBSCRIBE TO WPS
MEDICARE ENEWS - SIGN UP TODAY!**

WPS Medicare is pleased to offer the convenient services of our WPS Medicare eNews to all providers in our jurisdiction. WPS Medicare eNews is an electronic newsletter (Listserv) sent to you via e-mail. When you subscribe, WPS Medicare eNews will bring the latest Medicare news directly to your e-mail box, free of charge! You may unsubscribe at any time and, as with all aspects of the WPS Medicare publications, we value your privacy and will never disclose, give, sell or transfer any personally identifiable information to third parties.

WPS Medicare eNews announces the posting of the following:

- Time-sensitive national and local Medicare news
- Medicare program changes
- Policy updates, including new, retired, and revised policies
- Training events (including seminars, teleconferences, webinars, and on demand trainings!)
- *Communiqué* newsletters
- Specialty- and service-specific educational articles
- Much, much more!

It is important to note that the Centers for Medicare & Medicaid Services (CMS) requires Medicare contractors (including WPS Medicare) to increase provider subscribership to their Listservs every year. In addition, CMS has instructed that every Medicare provider (including physicians, nurses, and billing staff) should be subscribed to eNews. It is a common misconception that only one provider in an office can be subscribed to WPS Medicare eNews; CMS and WPS encourage and expect **ALL** Medicare providers to subscribe to eNews.

Sign up today! Visit our website at <http://www.wpsmedicare.com/listserv> to subscribe (it only takes a minute). And if you know a co-worker or another Medicare provider who isn't receiving WPS Medicare eNews, let them know that they're missing out on a very informative educational resource and direct them to <http://www.wpsmedicare.com/listserv> to sign up as well!

DOCUMENTATION OF ARTIFICIAL LIMBS

Dear Physician,

The Durable Medical Equipment Medical Administrative Contractors (DME MAC) have jurisdiction for processing claims from prosthetists for artificial limbs. In the event of an audit, the Medicare contractor may request medical records to demonstrate that the prosthetic arm or leg was reasonable and necessary. Since the prosthetist is a supplier, the prosthetist's records must be corroborated by the information in your patient's medical record. It is the treating physician's records, not the prosthetist's, which are used to justify payment.

The patient's functional capabilities are crucial to establishing the medical necessity for a prosthetic device. Many prosthetic components are restricted to specific functional levels;

therefore, it is critical that physicians thoroughly document the functional capabilities of their patients, both before and after amputation. Clinical assessments of a patient's rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference. Note that it is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

The physician's assessment of a patient's physical and cognitive capabilities typically includes:

- History of the present condition(s) and past medical history that is relevant to functional deficits
- Symptoms limiting ambulation or dexterity
- Diagnoses causing these symptoms
- Other co-morbidities relating to ambulatory problems or impacting the use of a new prosthesis
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used (either in addition to the prosthesis or prior to amputation)
- Description of activities of daily living and how impacted by deficit(s)
- Physical examination that is relevant to functional deficits
- Weight and height, including any recent weight loss/gain
- Cardiopulmonary examination
- Musculoskeletal examination
 - Arm and leg strength and range of motion
- Neurological examination
 - Gait
 - Balance and coordination

The assessment points above are not all-inclusive and physicians should tailor their history and examination to the individual patient's condition, clearly describing the pre and post-amputation capabilities of the patient. The history should paint a picture of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The

physical examination should be focused on the body systems that are responsible for the patient's ambulatory or upper extremity difficulties or impact on the patient's functional ability.

Note that when physicians are unable to provide the requested documentation to the supplier, the suppliers receive denials for the items billed which could result in your patient being financially responsible for all or part of the charges for the items/service received. If a supplier contacts your office to request additional clinical documentation, please partner with the supplier to establish what clinical records are needed to support that the service/item you ordered is medically necessary.

Section 1842(p)(4) of the Social Security Act mandates that:

[i]n case of an item or service...ordered by a physician or a practitioner...but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Providing medical records to the supplier is not a violation of the HIPAA Privacy Rule. Thank you for your cooperation in future documentation requests.

Sincerely,

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC Jurisdiction C
CGS

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 2012 (which runs from October 2011 through September 2012) **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 2011, March 2012, June 2012, and September 2012).

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."

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Claim Submission**INSTRUCTIONS TO ACCEPT AND PROCESS ALL AMBULANCE
TRANSPORTATION HEALTHCARE COMMON PROCEDURE CODING
SYSTEM (HCPCS) CODES
~ Revised CMS MLN Matters ~**

MLN Matters® Number: MM7489 Revised
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R942OTN

Related Change Request (CR) #: CR 7489
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: This article was revised on August 11, 2011, to add language emphasizing that CR7489 applies to ambulance transportation services and transportation related services. All other information remains the same.

Provider Types Affected

This article is for ambulance providers and suppliers who bill Medicare Carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MACs) for ambulance transportation services and transportation related services provided to Medicare beneficiaries.

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

Effective January 1, 2012, you will be able to submit “no-pay claims” to Medicare for statutorily excluded ambulance transportation services and transportation related services, in order to obtain a Medicare denial to submit to a beneficiary’s secondary insurance for coordination of benefits purposes.

CAUTION – What You Need to Know

Change Request (CR) 7489, from which this article is taken, announces that (effective January 1, 2012,) Medicare FIs, carriers, and A/B MACs will revise their claims processing systems to begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily excluded ambulance transportation services and transportation related services. Medicare will then deny claims containing these codes as “non-covered,” which will allow you to submit the denied claim to a beneficiary’s secondary insurance for coordination of benefits purposes.

GO – What You Need to Do

You should ensure that your billing staffs are aware of this change and the need to include the “GY” modifier to the HCPCS code identifying the excluded ambulance transportation service and transportation related services.

Background

Certain HCPCS codes identify various transportation services that are statutorily excluded from Medicare coverage and, therefore, not payable when billed to Medicare. In the Medicare Physician Fee Schedule Database (MPFSDB), a status indicator of “I” or “X” is associated with these codes. The “I” shows the HCPCS code is “Not valid for Medicare

purposes. Medicare uses another code for reporting of, and payment for, these services.” The “X” indicates a (Statutory Exclusion” of the code. (See the “Medicare Claims Processing Manual,” Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 30.2.2 (MPFSDB Status Indicators), which you can find at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.)

Because HCPCS codes are valid codes under the Health Insurance Portability and Accountability Act (HIPAA), claims for ambulance transportation and transportation related services (HCPCS codes A0021 through A0424 and A0998) which are statutorily excluded or otherwise not payable by Medicare should be allowed into the Medicare claims processing system for adjudication and, since these services are statutorily excluded from, or otherwise not payable by, Medicare, then denied as such. Doing so affords providers and suppliers submitting the claims on behalf of Medicare beneficiaries the opportunity to submit “no-pay claims” to Medicare for statutorily excluded or otherwise not payable by Medicare services with the HCPCS code that accurately identifies the service that was furnished to the Medicare beneficiary. Doing so will allow providers/suppliers to obtain a Medicare denial to submit to a beneficiary’s secondary insurance for coordination of benefits purposes.

If you wish to bill for statutorily excluded ambulance transportation services and transportation related services in order to obtain a “Medicare denial,” you should bill for such services by attaching the “GY” modifier to the HCPCS code identifying the service according to long-standing CMS policy.

When denying these claims for statutorily excluded services, your carrier, FI, or A/B MAC will use the following remittance advice language:

- Claim Adjustment Reason Code - 96 – “Non-covered charge(s);”
- Remittance Advice Remark Code - N425 – “Statutorily excluded service(s);” and
- Group Code - PR – “Patient Responsibility.”

Note: Make sure that you include the HCPCS code that accurately identifies the excluded ambulance transportation service and transportation related services that the beneficiary was furnished.

Additional Information

You can find more information about instructions given to your carrier, FI, or A/B MAC to accept and process all ambulance transportation HCPCS Codes by going to CR7489, located at <http://www.cms.gov/Transmittals/downloads/R942OTN.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.

JULY 2011 INTEGRATED OUTPATIENT CODE EDITOR (I/OCE) SPECIFICATIONS VERSION 12.2

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM7439 Revised
Related CR Release Date: May 20, 2011
Related CR Transmittal #: R2224CP

Related Change Request (CR) #: 7439
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Note: This article was revised on August 8, 2011, to add a reference to MM7443 (<http://www.cms.gov/MLNMArticles/Downloads/MM7443.pdf>) for the changes to various payment policies and billing instructions implemented in the July 2011 OPSS update. 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 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) 7439, which describes changes to the I/OCE and OPPS to be implemented in the July 2011 OPSS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR7439 describes changes to billing instructions for various payment policies implemented in the July 2011 OPSS update. The July 2011 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR7439.

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. In addition, numerous changes to Ambulatory Payment Classification (APC), HCPCS, and CPT codes, effective with the July 2011 I/OCE, are also listed in the Summary of Data Changes document attached to CR7439. The CR is available at <http://www.cms.gov/Transmittals/downloads/R2224CP.pdf> on the CMS website.

A summary of the I/OCE modifications for July 2011 is within Appendix M, which is attached to CR7439 and is summarized as follows:

- Effective January 1, 2011, Medicare will:
 - Implement logic to set Payment Adjustment Flag (PAF) 4:
 - If modifier 'PT' is present on any CPT code in the range 10000 – 69999 on a claim, apply PAF 4 to all codes in the range with the same date of service as the code with modifier PT. Exception: Do not apply PAF 4 to a line if any other PAF is applicable/already applied to the same line;
 - Add code G0010 to the list for PAF 9 (Deductible/Co-insurance not applicable).

- Effective July 1, 2011, Medicare will:
 - Make HCPCS/APC/SI changes (See the Summary of Data Changes attached to CR7439.);
 - Implement version 17.1 of the NCCI (as modified for applicable institutional providers). Edits 19, 20, 39 and 40 are affected; and
 - Update procedure/device and device/procedure edit requirements. Edits 71 and 77 are affected.

Additional Information

The official instruction, CR7439 issued to your Medicare MAC, RHHI, or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2224CP.pdf> on the CMS website.

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

MANUAL CLARIFICATIONS FOR SKILLED NURSING FACILITY (SNF) PART A BILLING ~ Revised CMS MLN Matters ~

MLN Matters® Number: MM7339 Revised
Related CR Release Date: June 17, 2011
Related CR Transmittal #: 2245CP

Related Change Request (CR) #: 7339
Effective Date: August 1, 2011
Implementation Date: August 1, 2011

Note: This article was revised on June 21, 2011, to revise language on page 2 (**Ancillary Services in bold**). The CR release date, transmittal number, and the web address for accessing CR7339 were also revised in this article. This article was previously revised on June 15, 2011, to clarify the usage of occurrence code 16 and the definition of billed therapy units on Part A SNF claims. In addition, the effective and implementation dates were revised to allow providers time to adjust their billing systems. All other information remains the same.

Provider Types Affected

SNFs, which submit claims to Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs), are affected by this article. This article contains no policy changes.

Provider Action Needed

This article is based on Change Request (CR) 7339, which provides various clarifications for SNF Part A billing. Please be sure to inform your staffs of these clarifications.

Background

The Centers for Medicare & Medicaid (CMS) is including the following clarifications to the "Medicare Claims Processing Manual," Chapter 6, SNF Inpatient Part A Billing.

Billing SNF Prospective Payment Services (PPS)

In all cases where an End of Therapy (EOT) – Other Medicare Required Assessment (OMRA) is completed, SNFs must submit occurrence code 16, date of last therapy, to

indicate the last day of therapy services (e.g. physical therapy, occupational, and speech language pathology) for the beneficiary.

Coding PPS Bills for Ancillary Services

For therapy services (revenue codes 042x, 043x, and 044x), units represent the number of sessions of therapy provided. For example, if the beneficiary received physical therapy, **occupational therapy or speech-language pathology** on May 1, that would be considered one calendar day and would be billed as one unit.

Reprocessing inpatient bills in sequence

When a beneficiary experiences multiple admissions (to the same or a different facility) during a benefit period, claims are processed by CWF in the same order that they are received, regardless of the dates on which expenses were incurred. This first-in-first-out (FI/FO) method of processing requests for payment facilitates prompt handling of claims.

If a SNF, any beneficiary, or secondary insurer have increased liability as a result of CWF's FI/FO processing, the SNF must notify the FI or A/B MAC to arrange reprocessing of all affected claims. This approach is not applicable if the liability stays the same, e.g., if the coinsurance or deductible amounts are applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage or if the beneficiary is responsible for payment of the first claim instead of the second.

The FI or A/B MAC will verify and cancel any bills posted out-of-sequence and request that any other FI or MAC involved also cancel any affected bills. The FI or MAC will reprocess all bills in the benefit period in the sequence of the beneficiary's stays to properly allocate days where payment is made in full by Medicare and to identify those days where the beneficiary is required to pay coinsurance.

Additional leave of absence guidance

Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them *except as specified in Chapter 1 of the Medicare Claims Processing Manual at Section 30.1.1.1*. Occurrence span code 74 is used to report the LOA from and through dates.

Clarification of technical component

Billing Related to Physician's Services: The technical component (*e.g. the component representing the performance of the diagnostic procedure itself*) of physician services delivered to SNF inpatients are bundled into the Part A PPS payment and not paid separately.

Additional Information

The official instruction, CR 7339 issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2245CP.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.

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

~CMS MLN Matters~

MLN Matters® Number: MM7454
Related CR Release Date: June 24, 2011
Related CR Transmittal #: R2246CP

Related Change Request (CR) #: 7454
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected

All Medicare providers and suppliers submitting claims to Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Carriers, A/B Medicare Administrative Contractors (MAC), and Durable Medical Equipment (DME) MACs are affected by this article.

Provider Action Needed

This article, based on Change Request (CR) 7454, informs you that the Centers for Medicare & Medicaid Services (CMS) is providing its annual reminder of the ICD-9-CM update that is effective for the dates of service on and after October 1, 2011 (effective for discharges on or after October 1, 2011, for institutional providers). Please be sure to inform your staffs of these updates.

Background

ICD-9 Information

The ICD-9-CM codes are updated annually. Effective since October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare contractors and MACs, with the exception of ambulance claims (specialty type 59).

CMS posts the new, revised, and discontinued ICD-9-CM diagnosis codes annually at http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp on the CMS website. The updated diagnosis codes are effective for dates of service and discharges on and after October 1. You may view the new updated codes at this site in June. You may also visit the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd.htm> on the Internet. The NCHS will post the new ICD-9-CM Addendum on their website in June. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM annually.

International Classification of Diseases, Tenth Revision (ICD-10) Information

CMS has posted a list of 2011 ICD-10-CM code descriptions in tabular order (the order they appear in the code book) at http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp on the CMS website. The tabular order version of ICD-10-CM will assist those who wish to identify a range of codes and make certain they have correctly identified all codes within the range. In addition, a list of 2012 ICD-10-PCS codes is at http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp on the CMS site. The 2012 ICD-10-CM list should be posted later this year and its posting will be conveyed via listserv notices.

Additional Information

The official instruction, CR 7454, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2246CP.pdf> on the 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.

**OCTOBER QUARTERLY UPDATE TO 2011 ANNUAL UPDATE OF
HCPCS CODES USED FOR SKILLED NURSING FACILITY (SNF)
CONSOLIDATED BILLING (CB) ENFORCEMENT**
~CMS MLN Matters~

MLN Matters® Number: MM7444
Related CR Release Date: June 3, 2011
Related CR Transmittal #: R2237CP

Related Change Request (CR) #: CR 7444
Effective Date: January 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs),) for Skilled Nursing Facility (SNF) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7444 which provides the October quarterly update to the 2011 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) enforcement. CR7444 instructs the Medicare system maintainers to add HCPCS code J0894 (Injection, decitabine, 1 mg) to the File 1 Coding List for SNF CB and to Major III.A Chemotherapy services list in the FI/A/B MAC file for dates of service on or after January 1, 2011.

Background

The Social Security Act (Section 1888; see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) codifies the Skilled Nursing Facility Prospective Payment System (SNF PPS) and consolidated billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. No additional services are added by these routine updates. New updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Services excluded from the SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to Medicare contractors, including Durable Medical Equipment (DME) MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB 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. In order to assure proper payment in all settings, Medicare must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR7444 instructs that:

- Medicare system maintainers will add Healthcare Common Procedure Coding System (HCPCS) code J0894 to the File 1 Coding List for SNF Consolidated Billing for dates of service on or after January 1, 2011; and
- Medicare system maintainers will add HCPCS code J0894 to Major Category III. A Chemotherapy services list in the FI/A/B MAC file effective January 1, 2011.

Note that Medicare contractors will reprocess claims affected by CR7444 when brought to their attention.

Additional Information

The official instruction, CR7444, issued to your carriers, FIs, or A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2237CP.pdf> on the CMS website.

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

Coverage – General**AUTOLOGOUS CELLULAR IMMUNOTHERAPY TREATMENT OF
METASTATIC PROSTATE CANCER****~CMS MLN Matters~**

MLN Matters® Number: MM7431

Related CR Release Date: July 8, 2011

Related CR Transmittal #: R2254CP and R133NCD

Related Change Request (CR) #: CR 7431

Effective Date: June 30, 2011

Implementation Date: August 8, 2011

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for metastatic prostate cancer treatment services provided to Medicare beneficiaries are affected.

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

This article is based on Change Request (CR) 7431 regarding the use of autologous cellular immunotherapy treatment for metastatic prostate cancer.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) finds that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer. It is therefore reasonable and necessary to use for this on-label indication under the Social Security Act (1862(a)(1)(A)) effective for services performed on or after June 30, 2011.

GO – What You Need to Do

Make sure billing staff is aware of this article.

Background

In 2010 the Food and Drug Administration (FDA) approved Sipuleucel-T (APC8015) for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as Docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.

The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent the proliferation of, cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

Change Request (CR) 7431 instructs that, effective for services performed on or after June 30, 2011, CMS concludes that the evidence is adequate to support the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer.

Medicare contractors will continue to process claims for PROVENGE® with dates of service on June 30, 2011, as they do currently when providers submit Not Otherwise Classified Healthcare Common Procedure Coding System (HCPCS) code(s) J3590, J3490, or C9273. **HCPCS code C9273 will be deleted on June 30, 2011.**

The new HCPCS code Q2043 will:

- Replace C9273 (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion);
- Be implemented in the July 2011 Update of Quarterly HCPCS Drug/Biological Code Changes (CR 7303 (Transmittal R2227CP); see <http://www.cms.gov/transmittals/downloads/R2227CP.pdf> on the CMS website); and
- Have an effective date of **July 1, 2011.**

The Ambulatory Surgical Center (ASC) Payment System will be updated to reflect these coding changes, and these changes will be announced in the ASC Quarterly Update CR for July 2011.

Coverage for PROVENGE®, Q2043, for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer is limited to one (1) treatment regimen in a patient's lifetime, consisting of three (3) doses with each dose administered approximately two (2) weeks apart for a total treatment period not to exceed 30 weeks from the first administration.

The language given in the long descriptor of Provenge® that states "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient, as well as the infusion of the immune cells to the patient. Q2043 is all-inclusive and represents all routine costs associated with its administration. Thus contractors will not pay separately for any claims of routine costs associated with PROVENGE®, such as Common Procedure Terminology (CPT) code 96365, "intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour".

Note: For a local coverage determination by an individual MAC to cover PROVENGE® "off-label" for the treatment of prostate cancer, the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code must be either 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate). ICD-9 diagnosis code 233.4 may not be used for "on-label" coverage claims.

Coding and Billing Information

ICD-9 Diagnosis Coding

For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:

ICD-9 code	Description
196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified - The spread of cancer to and establishment in the lymph nodes.
197.0	Secondary malignant neoplasm of lung – Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.
197.7	Malignant neoplasm of liver secondary - Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.
198.0	Secondary malignant neoplasm of kidney - The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow – Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of adrenal gland
198.82	Secondary malignant neoplasm of genital organs

Coding for Off-Label PROVENGE® Services

At the discretion of the local Medicare Administrative Contractors, claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043. Effective with the implementation date for ICD-10 codes, off-label PROVENGE® services must be billed with either ICD-10 code D075 (carcinoma in situ of prostate) or C61 (malignant neoplasm of prostate) in addition to HCPCS Q2043.

ICD-10 Diagnosis Coding

The appropriate ICD-10 code(s) that are listed below are for future implementation.

ICD-10	Description
C61	Malignant neoplasm of prostate (for on-label or off-label indications)
D075	Carcinoma in situ of prostate (for off-label indications only)
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.7	Secondary malignant neoplasm of liver
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.82	Secondary malignant neoplasm of genital organs

Types of Bill (TOB) and Revenue Codes

The applicable TOBs for PROVENGE® are: 12X, 13X, 22X, 23X, 71X, 77X, and 85X.

On institutional claims, TOBs 12X, 13X, 22X, 23X, and 85X, use revenue code 0636 - drugs requiring detailed coding.

Payment Methods

Payment for PROVENGE® is as follows:

- TOBs 12X, 13X, 22X and 23X - based on the Average Sales Price (ASP) + 6%,
- TOB 85X – based on reasonable cost,
- TOBs 71X and 77X – based on all-inclusive rate (drugs/supplies are not reimbursed separately).
- For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6%.

Note: Medicare Contractors will not pay separately for routine costs associated with PROVENGE®. HCPCS Q2043 is all-inclusive and represents all routine costs associated with its administration.

Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs), and Group Codes

Medicare will use the following messages when denying claims for the on-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 185 and at least one diagnosis code from the ICD-9 table shown above:

- RARC 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group Code - Contractual Obligation (CO)

Medicare will use the following messages when denying line items on claims for the off-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 233.4 or 185:

- RARC 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group Code – CO.

When denying claims for PROVENGE®, HCPCS Q2043® that exceed three (3) payments in a patient's lifetime, contractors shall use the following messages:

- RARC N362 - The number of Days or Units of Service exceeds our acceptable maximum.
- CARC 149 - Lifetime benefit maximum has been reached for this service/benefit category.
- Group Code - CO.

When denying claims for PROVENGE®, HCPCS Q2043® that are provided more than 30 weeks from the date of the 1st PROVENGE® administration, contractors shall use the following messages:

- CARC B5 – Coverage/program guidelines were not met or were exceeded.
- Group Code – CO.

Additional Information

The official instruction, CR 7431, was issued to carriers, FIs, and A/B MACs via two transmittals. The first modifies the *National Coverage Determinations Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R133NCD.pdf> on the CMS website. The

second updates the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R2254CP.pdf> on the CMS website.

If you have any questions, please contact your carriers, FIs or A/B MACs, 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 2011 ~CMS MLN Matters~

MLN Matters® Number: MM7507
Related CR Release Date: July 22, 2011
Related CR Transmittal #: R2257CP

Related Change Request (CR) #: 7507
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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) 7507, which announces the changes that will be included in the October 2011 release of Medicare's edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in April 2011. Be sure billing staff know about 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.

CR7507 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2011. These changes become effective for services furnished on or after October 1, 2011. The changes that are effective for dates of service on and after October 1, 2011 are as follows:

- For Codes That Are Denied By Medicare For All 23 Lab NCDs:
 - Delete ICD-9-CM code V19.1 from the list of ICD-9-CM codes that are denied by Medicare for all 23 Lab NCDs.
 - Add ICD-9-CM codes V19.11 and V19.19 to the list of ICD-9-CM codes that are denied by Medicare for all 23 Lab NCDs.

- For Codes That Do Not Support Medical Necessity For The Blood Counts
 - Add ICD-9-CM code V54.82 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- For Partial Thromboplastin Time
 - Delete ICD-9-CM codes 286.5, 444.0, and 596.8 from the list of ICD-9-CM codes that are covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
 - Add ICD-9-CM codes 286.52, 286.53, 286.59, 444.01, 444.09, 596.81, 596.82, 596.83, and 596.89 to the list of ICD-9-CM codes that are covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- For Prothrombin Time
 - Delete ICD-9-CM codes 286.5, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
 - Add ICD-9-CM codes 286.52, 286.53, 286.59, 415.13, 444.01, 444.09, 596.81, 596.82, 596.83, 596.89, 997.41, 997.49, and V12.55 to the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- For Serum Iron Studies
 - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.
 - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.
- For Blood Glucose Testing
 - Add ICD-9-CM codes V23.42 and V23.87 to the list of ICD-9-CM codes that are covered by Medicare for the Blood Glucose Testing (190.20) NCD.
- For Glycated Hemoglobin/Glycated Protein
 - Delete ICD-9-CM code V12.2 from the list of ICD-9-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
 - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- For Thyroid Testing:
 - Delete ICD-9-CM code V12.2 from the list of covered ICD-9-CM codes for the Thyroid Testing (190.22) NCD.
 - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the Thyroid Testing (190.22) NCD.

- For Lipids Testing
 - Delete ICD-9-CM code 444.0 from the list of ICD-9-CM codes that are covered by Medicare for the Lipids Testing (190.23) NCD.
 - Add ICD-9-CM codes 444.01 and 444.09 to the list of ICD-9-CM codes that are covered by Medicare for the Lipids Testing (190.23) NCD.
- For Human Chorionic Gonadotropin
 - Delete ICD-9-CM code 631 from the list of ICD-9-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
 - Add ICD-9-CM codes 631.0 and 631.8 to the list of ICD-9-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
- For Gamma Glutamyl Transferase:
 - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of covered ICD-9-CM codes for the Gamma Glutamyl Transferase (190.32) NCD.
 - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, and 173.99 to the list of ICD-9-CM codes that are covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- For Fecal Occult Blood Test
 - Delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
 - Add ICD-9-CM codes 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.

Additional Information

The official instruction, CR7507 issued to your carrier, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2257CP.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.

USUALLY SELF-ADMINISTERED DRUG 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, 2011, 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:

Legacy: http://www.wpsmedicare.com/part_a/policy/usad_listing/

MAC: http://www.wpsmedicare.com/j5macparta/policy/usad_listing/

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:

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

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

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.

WPS Medicare Part A
Freedom of Information
P.O. Box 1604
Omaha, NE 68101
Fax Number: (402) 995-0604



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/medicare-coverage-database/overview-and-quick-search.aspx>

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

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

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

July 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Bone Mass Measurement	L31620	MS-004	08/15/2011

August 2011

There are no new policies for August 2011.

September 2011

There are no new policies for September 2011.

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:

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

MAC: <http://www.wpsmedicare.com/i5macparta/policy/updates/retired/>

July 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Bone Mass Measurement This LCD is retired and replaced by an LCD of the same name (L31620).	L28527	MS-004	08/14/2011
Leg	Stereotactic Body Radiation Therapy (SBRT) Policy L26109, Stereotactic Body Radiation Therapy (SBRT), is being retired and is being replaced with policy L28366 Stereotactic Body Radiation Therapy.	L26109	N/A	07/01/2011

August 2011

There are no retired policies for August 2011.

September 2011

There are no retired policies for September 2011.

REVISED POLICIES

The following are revised 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/medicare-coverage-database/overview-and-quick-search.aspx>

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

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

MAC: <http://www.wpsmedicare.com/i5macparta/policy/updates/revised/>

July 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Cardiac Catheterization and Coronary Angiography Billing and Coding Guidelines: 07/01/2011 Added new physician specialty code 21(Cardiac Electrophysiology) effective 04/01/2011. 13. Cardiac catheterizations will be payable when performed by the following specialties:	L30719	CV-006	04/01/2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	06-Cardiology, 78-Cardiac Surgery 21-Cardiac Electrophysiology When a right heart catheterization, procedure code 93451, is being done for hemodynamic evaluation of pulmonary hypertension and billed with diagnosis codes 416.0 or 416.8. 29- Pulmonologist 81- Critical care intensivist			
MAC	Chemotherapy Drugs and their Adjuncts	L28576	HONC-010	07/01/2011
	Indications and Limitations of Coverage and/or Medical Necessity: C. The following drugs are covered for the following indications: 34. Oxaliplatin (Eloxatin™) 0.5 mg (J9263) Intrahepatic bile ducts 155.1 Chronic Lymphoid Leukemia 204.10, 204.12 49. Sipuleucel-T, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion (Q2043) (Provenge®). Q2043 has been added and C9273 has been deleted based on Change Request (CR) 7445, "July 2011 Update of the Ambulatory Surgical Center (ASC) Payment System." Coverage of Sipuleucel-T (Provenge®) was moved from D. Not otherwise Classified Agents (NOC) section to C. #49. F. Coverage of Cyclophosphamide (J9070) and Methotrexate (J9250, J9260) for indications other than oncologic diseases. 2. Methotrexate (J9250, J9260) n. Ankylosing spondylitis 720.0			
Leg/ MAC	Computerized Corneal Topography	L31064	OPHTH-014	07/01/2011
	Clarified LCD to state that corneal topography should not be reported with or during the post-operative period for corneal procedures, e.g., 65710, 65730, 65750, 65755, 65756, 65757, and 65770. Removed statements 1, 2, 3, 4, and 5 listed in the section entitled "Indications and Limitations of Coverage and/or Medical Necessity." For the purpose of clarity, added a section entitled "Indications." which now states; Computerized corneal topography is considered medically necessary under any of the following conditions: 1. pre-operative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery 2. monocular diplopia 3. diagnosis of early keratoconus; 4. post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters; 5. suspected irregular astigmatism based on retinoscopic streak or conventional keratometry; 6. post-penetrating keratoplasty surgery;			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	<p>7. post-surgical or post-traumatic irregular astigmatism; 8. certain corneal dystrophies; 9. complications of transplanted cornea; 10. post-traumatic corneal scarring; and or 11. pterygium and or corneal ectasia that cause visual impairment</p> <p>Clarified and added the following instructions to "Utilization Guidelines" section *It is expected that computerized corneal topography would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.</p> <p>*Repeat testing is only indicated if a change in vision occurs with one of the conditions listed under the Indications section of this LCD.</p> <p>*Corneal topography should not be reported with or during the post-operative period for corneal procedures, e.g., 65710, 65730, 65750, 65755, 65756, 65757, and 65770. Coding instructions for CPT codes 65710, 65730, 65750, 65755, 65756, 65757, and 65770 effective from DOS 12/16/2010 and thereafter.</p> <p>Billing and Coding Guidelines Attachment: For the purpose of clarity, added section entitled "Specific Coding Guidelines for This Policy" which states; Do not report CPT code 92025 when computerized corneal topography is performed in conjunction with keratoplasty procedures described by CPT codes 65710, 65730, 65750, 65755, 65756, 65757, and 65770. Computerized corneal topography is considered to be integral to the postoperative management of these keratoplasty procedures. (AMA, CPT Changes 2007 - An Insider's View).</p> <p>Coding instructions for CPT codes 65710, 65730, 65750, 65755, 65756, 65757, and 65770 effective from DOS 12/16/2010 and thereafter.</p> <p>CPT codes 65760, 65765, 65767, and 65771 are status "N" on the Medicare Physician Fee Schedule. Corneal topography will be non-covered if performed pre - or post-operatively in relation to a Medicare non-covered procedure, i.e., radial keratotomy</p> <p>For claims submitted to the carrier Part B MAC Removed incorrect information, statement number one (1), paragraphs a and b, found in this section. Addition of revised instructions for the section entitled For claims submitted to the carrier Part B MAC.</p> <ul style="list-style-type: none"> • All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same day. • Claims for computerized corneal topography services are payable under Medicare Part B in the following places of service: • For the global service - office (11), nursing facility (32 - for Medicare patient not in a Part A stay). • For the technical component (modifier TC) - office (11), nursing facility (32 - for 			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date												
	<p>Medicare patient not in a Part A stay), federally qualified health center (50), and rural health clinic (72).</p> <ul style="list-style-type: none"> For the professional component (modifier 26) - office (11), inpatient hospital (21), outpatient hospital (22), skilled nursing facility for patients in a part A stay (31), nursing facility (32 - for Medicare patient not in a Part A stay). 															
Leg/ MAC	<p>Computerized Tomography (CAT Scans)</p> <p>Addition of ICD-9 codes 358.00 and 358.01 to the CT Chest and Thorax (71250-71270) section.</p> <p>Addition of ICD-9 codes 780.09, V71.4 and V71.89 to the CT Cervical Spine (72125-72127) section.</p> <p>ICD-9 coding additions effective for DOS 05/01/2011, and thereafter.</p>	L28544	RAD-033	07/01/2011												
Leg/ MAC	<p>Hemophilia Clotting Factors</p> <p>Effective 07/01/2011, Q2041, Injection, Von Willebrand factor complex (human), Wilate, 1 I.U. will replace J7184, Injection, von Willebrand factor complex (human), Wilate, per 100 IU effective January 1, 2011 Implementation date July 5,2011. This is based on CR 7430. Please note the change in the dosage.</p>	L31078	INJ-003	07/01/2011												
Leg/ MAC	<p>Polysomnography and Other Sleep Studies</p> <p>ICD-9 code 327.21 was added to our list of covered conditions for CPT 95811- polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist.</p> <p>Medicare is establishing the following limited coverage for CPT/HCPCS code 95811: 327.21 Primary central sleep apnea</p>	L31082	NEURO-009	07/01/2011												
Leg/ MAC	<p>Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)</p> <p>ICD-9 Codes that Support Medical Necessity: 77301, 77418, 0073T (IMRT) *209.31-209.36 Merkel cell carcinoma</p>	L30316	RAD-014	04/01/2011												
Leg	<p>Stereotactic Body Radiation Therapy (SBRT)</p> <p>The new version of this policy expands coverage to include SBRT for prostate cancer among other areas. The ICD-9 codes for the new document are as follows:</p> <p>ICD-9 Codes that Support Medical Necessity Note: ICD-9 codes must be coded to the highest level of specificity.</p> <table border="1"> <tbody> <tr> <td>155.0</td> <td>Malignant neoplasm of liver primary</td> </tr> <tr> <td>155.1</td> <td>Malignant neoplasm of intrahepatic bile ducts</td> </tr> <tr> <td>155.2</td> <td>Malignant neoplasm of liver not specified as primary or secondary</td> </tr> <tr> <td>157.0-157.9</td> <td>Malignant neoplasm of head of pancreas</td> </tr> <tr> <td>162.0-162.9</td> <td>Malignant neoplasm of trachea, bronchus and lung</td> </tr> <tr> <td>185</td> <td>Malignant neoplasm of prostate</td> </tr> </tbody> </table>	155.0	Malignant neoplasm of liver primary	155.1	Malignant neoplasm of intrahepatic bile ducts	155.2	Malignant neoplasm of liver not specified as primary or secondary	157.0-157.9	Malignant neoplasm of head of pancreas	162.0-162.9	Malignant neoplasm of trachea, bronchus and lung	185	Malignant neoplasm of prostate	L28366	RAD-039	07/01/2011
155.0	Malignant neoplasm of liver primary															
155.1	Malignant neoplasm of intrahepatic bile ducts															
155.2	Malignant neoplasm of liver not specified as primary or secondary															
157.0-157.9	Malignant neoplasm of head of pancreas															
162.0-162.9	Malignant neoplasm of trachea, bronchus and lung															
185	Malignant neoplasm of prostate															

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	189.0	Malignant neoplasm of kidney except pelvis		
	189.1	Malignant neoplasm of renal pelvis		
	194.0	Malignant neoplasm of adrenal gland		
	194.6	Malignant neoplasm of aortic body and other paraganglia		
	197.0	Secondary malignant neoplasm of lung		
	197.7	Malignant neoplasm of liver secondary		
	197.8	Secondary malignant neoplasm of other digestive organs and spleen		
	198.0	Secondary malignant neoplasm of kidney		
	198.89	Secondary malignant neoplasm of other specified sites		
	227.6	Benign neoplasm of aortic body and other paraganglia		
	234.8	Carcinoma in situ of other specified sites		
	237.3	Neoplasm of uncertain behavior of paraganglia		
	990	Effects of radiation unspecified		
	<p>ICD-9-CM 197.8 is limited to secondary malignant neoplasms of pancreas and may not be used for other diagnoses.</p> <p>ICD-9-CM 990 may only be used where prior radiation therapy to the site is the governing factor necessitating SBRT in lieu of other radiotherapy. An ICD-9-CM code for the anatomic diagnosis must also be used.</p> <p>Please review the entire version on our website.</p>			
MAC	Stereotactic Body Radiation Therapy (SBRT)	L28366	RAD-039	07/01/2011
	This policy has been expanded to include Legacy A states.			

August 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
MAC	Chemotherapy Drugs and their Adjuncts	L28576	HONC-010	08/01/2011
	<p>Indications and Limitations of Coverage and/or Medical Necessity:</p> <p>C. The following drugs are covered for the following indications:</p> <p>10. Cetuximab (Erbix) (J9055) 10 mg -As a single agent or in combination with irinotecan after first progression except in patients receiving capecitabine or fluorouracil and leucovorin with bevacizumab.</p> <p>22. Gemcitabine Hydrochloride (Gemzar) 200 mg (J9201) Uterine -as a single agent or used in combination with docetaxel for unresectable disease limited to the uterus. May be considered following hysterectomy with bilateral salpingo-oophorectomy (TH/BSO) for stage I-III disease. 179, 180.0, 182.0-182.8</p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	<p>30. Melphalan Hydrochloride (Alkeran) (J9245) per 50 mg Non-Hodgkin's Lymphoma (NHL) 200.00-200.88, 202.00-202.98 Bone marrow ablation or preparation of a peripheral stem cell transplant for a Medicare covered transplant V42.81, V42.82</p> <p>43. Romidepsin (Istodax) 1 mg (J9315) effective FDA approval date Cutaneous T- cell lymphoma (CTCL) in patients that have received at least one prior systemic therapy (202.00-202.98). (Effective 11/05/2009)</p> <p>Peripheral T-cell lymphoma (PTCL) in patients that have received at least one prior therapy. (202.70-202.78) (Effective FDA approval date-06/16/2011)</p> <p>E. Monoclonal Antibodies that are useful in chemotherapeutic regimens:</p> <p>1. Rituximab (Rituxan) 100 mg, (J9310) Hodgkin's Lymphoma 201.40-201.48</p> <p>Moved information on Q2043 Sipuleucel-T (Provenge®) from the LCD to the billing and coding guidelines and included information from the new NCD -<i>Section 110.22 Autologous Cellular Immunotherapy Treatment (Effective June 30, 2011)(CR 7431-Transmittal 133) and Claims Processing Manual- Change Request 7431-transmittal 2254.</i></p> <p>Billing and Coding Guideline for HONC-010 Chemotherapy Drugs and their Adjuncts: <i>Publication 100-03 Medicare NCD Manual, Section 110.22 - Autologous Cellular Immunotherapy Treatment (Effective June 30, 2011)(CR 7431-Transmittal 133)</i></p> <p>A. General Prostate cancer is the most common non-cutaneous cancer in men in the United States. In 2009, an estimated 192,280 new cases of prostate cancer were diagnosed and an estimated 27,360 deaths were reported. The National Cancer Institute states that prostate cancer is predominantly a cancer of older men; the median age at diagnosis is 72 years. Once the patient has castration-resistant, metastatic prostate cancer the median survival is generally less than two years.</p> <p>In 2010, the Food and Drug Administration (FDA) approved sipuleucel-T (PROVENGE®; APC8015), for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.</p> <p>The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent, the proliferation of cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells.</p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	<p>Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.</p> <p>Sipuleucel-T differs from other infused anti-cancer therapies. Most such anti-cancer therapies are manufactured and sold by a biopharmaceutical company and then purchased by and dispensed from a pharmacy. In contrast, once the decision is made to treat with sipuleucel-T, a multi-step process is used to produce sipuleucel-T. Sipuleucel-T is made individually for each patient with his own white blood cells. The patient's white blood cells are removed via a procedure called leukapheresis. In a laboratory the white blood cells are exposed to PA2024, which is a molecule created by linking prostatic acid phosphatase (PAP) with granulocyte/macrophage-colony stimulating factor (GM-CSF). PAP is an antigen specifically associated with prostate cancer cells; GM-CSF is a protein that targets a receptor on the surface of white blood cells. Hence, PAP serves to externally manipulate the immunological functioning of the patient's white blood cells while GM-CSF serves to stimulate the white blood cells into action. As noted in the FDA's clinical review, each dose of sipuleucel-T contains a minimum of 40 million treated white blood cells, however there is "high inherent variability" in the yield of sipuleucel-T from leukapheresis to leukapheresis in the same patient as well as from patient to patient. The treated white blood cells are then infused back into the same patient. The FDA-approved dosing regimen is three doses with each dose administered two weeks apart. The total treatment period is four weeks.</p> <p>Nationally Covered Indications</p> <p>Effective for services performed on or after June 30, 2011, The Centers for Medicare and Medicaid Services (CMS) proposes that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer, and thus is reasonable and necessary for this on-label indication under 1862(a)(1)(A) of the Social Security Act.</p> <p>Effective for services performed on or after June 30, 2011, coverage of all off-label uses of autologous cellular immunotherapy treatment - sipuleucel-T; PROVENGE® for the treatment of prostate cancer is left to the discretion of the local Medicare Administrative Contractors.</p> <p>Publication 100-04, Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services (CR 7431-transmittal 2254) 280 - Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer 280.1 - Policy 280.2 - Healthcare Common Procedure Coding System (HCPCS) Codes and Diagnosis Coding 280.3 - Types of Bill (TOB) and Revenue Codes</p> <p>Effective for claims with dates of service on and after July 1, 2011, Medicare providers shall report the following HCPCS code: Q2043 - Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with</p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion; short descriptor, Sipuleucel-T auto CD54+.			
	ICD-9 Diagnosis Coding: For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:			
	ICD-9 Code	Description		
	196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes		
	196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes		
	196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb		
	196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes		
	196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites		
	196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified - The spread of cancer to and establishment in the lymph nodes.		
	197.0	Secondary malignant neoplasm of lung - Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.		
	197.7	Malignant neoplasm of liver secondary - Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.		
	198.0	Secondary malignant neoplasm of kidney - The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.		
	198.1	Secondary malignant neoplasm of other urinary organs		
	198.5	Secondary malignant neoplasm of bone and bone marrow - Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.		
	198.7	Secondary malignant neoplasm of adrenal gland		
	198.82	Secondary malignant neoplasm of genital organs		
	Coding for Off-Label PROVENGE® Services <i>The use of PROVENGE® off-label for the treatment of prostate cancer is left to the</i>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	<p><i>discretion of the Medicare Administrative Contractors. Claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate), or ICD-9 code 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043.</i></p> <p>WPS does not cover Provenge for any off label indications.</p> <p>280.3 - Types of Bill (TOB) and Revenue Codes (Rev. 2254, Issued: 07-08-11, Effective: 06-30-11, Implementation: 08-08-11 and 01-03-12 (CWF frequency edit only)</p> <p><i>The applicable TOBs for PROVENGE® are 12X, 13X, 22X, 23X, 71X, 77X, and 85X. On institutional claims, TOBs 12X, 13X, 22X, 23X, and 85X, use revenue code 0636 - drugs requiring detailed coding</i></p> <p>280.4 - Payment Method (Rev. 2254, Issued: 07-08-11, Effective: 06-30-11, Implementation: 08-08-11 and 01-03-12 (CWF frequency edit only)</p> <p><i>Payment for PROVENGE® is as follows:</i></p> <ul style="list-style-type: none"> • TOBs 12X, 13X, 22X and 23X - based on the Average Sales Price (ASP) + 6%, • TOB 85X - based on reasonable cost, • TOBs 71X and 77X - based on all-inclusive rate. <p><i>For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6%.</i></p> <p><i>Contractors shall not pay separately for routine costs associated with PROVENGE®. HCPCS Q2043 is all-inclusive and represents all routine costs associated with its administration.</i></p>			
Leg/ MAC	Paravertebral Facet Joint Block and Facet Joint Denervation Billing and Coding Guidelines	L30483	NEURO-008	03/18/2010
	<p>07/05/2011 correction to Paravertebral Facet Joint Denervation number 3. Fluoroscopic guidance and localization for needle placement, is not included in codes 64622-64627 effective 03/18/2010.</p>			

September 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	2012 ICD-9-CM Coverage	Various	Various	10/01/2011
	<p>Effective for claims submitted with dates of service on or after 10/01/2011, WPS will cover the new 2012 ICD-9-CM codes for the policies and procedures listed below. The listed changes to these effected policies will be posted to the websites after 10/01/2011.</p>			
	Policy Name/Number	Policy Procedure Code	2012 ICD-9-CM Changes/Additions/Deletions	
	L30729 3D Interpretation and Reporting of	76376, 76377	Add 793.11 and 793.19	

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	Imaging Studies RAD-037			
	L30471 Allergy Testing and Allergy Immunotherapy ALRG-001	95180 and 95004, 95010, 95024, 95027	Added 999.41-999.49; 999.51- 999.59	
	Bariatric Surgery for Morbid Obesity GSURG-042 (NCD)	43644, 43645, 43770, 43845, 43846, 43847	Secondary Diagnosis List Add 997.49	
	L31620 Bone Mass Measurement MS-004	77080	Add V58.68 Deleted V58.69 from this LCD	
	L30719 Cardiac Catheterization and Coronary Angiography CV-006	93451, 93452, 93453, 93454 93455, 93456, 93457, 93458 93459, 93460, 93461 93530, 93531, 93532, 93533 93563, 93564, 93565	Added 414.4, 415.13, 425.11, 425.18, 747.31, 747.32, 747.39, 998.00, 998.01, 998.02, 998.09 Added 747.31, 747.32, 747.39	
	L28563 Cardiovascular Stress Testing CV-004	93015, 93016, 93017, 93018	Added 425.11, 425.18	
	L28576 Chemotherapy Drugs and their Adjuncts HONC-010 FA57 CB@L	J9190 J9040, J9045, J9050, J9060, J9070, J9213, J9214 J9265 J9250, J9260	Added 365.70, 365.71, 365.72, 365.73 Added 173.00-173.99 Added 173.01, 173.11, 173.21, 173.31, 173.41, 173.51, 173.61, 173.71, 173.81, 173.91 Deleted 239.2 Added 516.30, 516.31, 516.32, 516.33, 516.36, 516.37	
	L28544 Computerized Tomography (CAT Scans) RAD-033	70450-70498 71250-71270 72191- 72194,	Add 173.00-173.99, 294.20, 294.21 310.81 310.89, 331.6; 348.82, 379.27, 999.32, 999.33, and 999.34. Add 173.00-173.99, 415.13 425.11, 425.18, 508.2, 512.2, 512.81, 512.82, 512.83, 512.84, 512.89, 518.51, 518.52, 518.53, 747.31, 747.32, 747.39, 793.11, 793.19, 997.32, 998.00, 998.01, 998.02 and 998.09. Add 173.00-173.99, 282.40,	

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
		74150-74175, 74176, 74177, 74178, 75635	282.43, 282.44, 282.45, 282.46, 282.47; 444.01, 444.09, 573.5, 596.81, 596.82, 596.83, 596.89, 808.44, 808.54, 996.88, 997.41, 997.49, 998.00, 998.01, 998.02 and 998.09.	
		72125-72127 72128-72130 72131-72133 73200-73206	Add 173.00-173.99 Add 173.00-173.99 Add 173.00-173.99 Add 173.00-173.99, 726.13.	
		73700-73706	Add.173.00-173.99	
	L30485 Corneal Pachymetry OPHTH-025	76514 (Group 3) 76514 (Group 4)	Add 996.88 Add 365.05, 365.06, 365.70, 365.71, 365.72, 365.73, 365.74	
	L30733 Cosmetic and Reconstructive Surgery GSURG-032	19316, 19318, 19324, 19325, 19340, 19342 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396	Added 173.50, 173.51, 173.52, 173.59	
		15775, 15776 30400-30450	Added 173.30, 173.31, 173.32, 173.39	
	L30300 CT Colonography (Virtual Colonoscopy [VC]) RAD-035	74261, 74262	Added 286.52, 286.53, 286.59	
	L30487 Cytogenetic Studies Path 027	88230, 88235, 88262, 88267, 88269, 88283, 88289	Added 630-631.8	
		88230, 88237, 88239, 88262, 88271, 88272, 88273, 88274, 88275, 88283	Added 173.00-173.99; 284.01- 284.09; 284.19, 284.2 - 284.9	
	L30510 Electromagnetic Navigation Bronchoscopy (ENB) PULM-007	31627	Add 793.11	
	L30481 Epidural and Transforaminal Epidural Injections NEURO-007	62281, 62282, 62310, 62311 62318, 62319, 64479, 64480 64483, 64484	Added 173.00-173.99, 808.44, 808.54. Description change for codes 808.43 and 808.53.	
	L30161 Flow Cytometry	88184-88189	Added 284.19	

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	PATH-016			
	L31078 Hemophilia Clotting Factors INJ-003	Q2041, J7185, J7186, J7187, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198		Added 286.52-286.59
	L30153 Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma MS-007	20550, 20551		Added 726.13
	L31355 Magnetic Resonance Angiography RAD-023	71555 72198 & 74185 73725		Add 415.13 and V12.55 Add 444.01 and 444.09 Add 415.13
	L28723 Magnetic Resonance Imaging RAD-024	70336, 70540- 70543, 70551- 70553 71550-71552 72195-72197, 74181-74183 73218-73223 75557, 75559, 75561, 75563		Add 173.40, 173.41, 173.42, 173.49 294.20, 294.21, 310.81 and 310.89, 379.27, 999.32, 999.33 and 999.34. Deleted from this section typographical coding error 173.6. Add 173.50, 173.51, 173.52, 173.59, 415.13, 425.11, 425.18, 508.2, 512.2 512.81, 512.82, 512.83, 512.84, 512.89, 518.51, 518.52, 518.53, 747.31, 747.32. 747.39, 793.11, 793.19, 997.32. Add 282.40, 282.43, 282.44, 282.45, 282.46, 282.47, 444.01, 444.09, 573.5, 596.81, 596.82, 596.89, 808.44, 808.54, 996.88, 997.41, 997.49, 998.00, 998.01, 998.02, and 998.09. Add 173.60, 173.61, 173.62, and 173.69. Add 414.4, 425.11 and 425.18;
	L30713 Mohs Micrographic Surgery DERM-004	17311, 17312, 17313, 17314, and 17315		Add 173.0, 173.1, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8
	L31072 Myocardial Perfusion Imaging and Cardiac Blood Pool Studies CV-017	78451, 78452, 78453, 78454 78466, 78468, 78469, 78472 78473, 78481, 78483, 78494 78496		Added 414.4, 425.11, 425.18
	L31346 Nerve Conduction Studies and	51785, 95860, 95861, 95863,		ICD-9 code 358.30 – 358.39 truncated 358.3

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	Electromyography NEURO-005	95864, 95865, 95866, 95867, 95868, 95869, 95870 95872, 95873, 95874, 95900, 95903, 95904, , 95905, 95933, 95934, 95936, 95937, 95999, G0255		
	L28586 Noninvasive Vascular Testing (N.I.V.T.) CV-033	93922-93931; 93978-93979 93965-93971	Added 444.01, 444.09 Added 786.30,768.39 (2010)	
	L29971 Optical Coherence Tomography (OCT) OPHTH-015	92133 and 92134	Add 379.27, 365.70, 365.71, 365.72, 365.73 and 365.74	
	Pet Scans (NCD)	78608, 78811, 78812,78813, 78814, 78815 78816 78608	Initial Treatment* 173.00 - 173.99 294.20-294.21; 331.6	
	L28574 Transesophageal Echocardiography (Including Intraoperative TEE) CV-007	93312, 93313, 93314, 93315, 93316, 93317	Add 415.13, 425.11, 425.18 747.31, 747.32, 747.39, 998.00, 998.01, 998.02 and 998.09.	
	L28565 Transthoracic Echocardiography (TTE) CV-026	93303, 93304, 93306, 93307, 93308, 93320, 93321, 93325, 93350 and 93351	Add 414.4, 415.13, 425.11, 425.18, 444.00, 444.09, 518.51, 518.52, 518.53, 747.31, 747.32, 747.39, 998.00, 998.01, 998.02, 998.09, 99.41, 999.42, 999.49, 999.51, 999.52, and 999.59.	
	L30151 Thrombopoietic Growth factor - Oprelvekin INJ-034	J2355	173.00-173.99	
	L31348 Visual Fields OPHTH-054	92081, 92082 and 92083	Add 365.05, 365.06, 365.70, 365.71, 365.72, 365.73, 365.74, and 379.27	
MAC	Chemotherapy Drugs and their Adjuncts	L28576	HONC-010	09/01/2011
	Indications and Limitations of Coverage and/or Medical Necessity			
	C. The following drugs are covered for the following indications:			
	22. Gemcitabine Hydrochloride (Gemzar) 200 mg (J9201) Extrahepatic bile duct 156.1, 156.2, 156.8, 156.9			
	44. Streptozocin (Zanosar), 1 gram (J9320) Carcinoid Tumor 209.00-209.29, 209.70-209.74			
	E. Monoclonal Antibodies that are useful in chemotherapeutic regimens:			
	1. Rituximab (Rituxan) 100 mg, (J9310) Microscopic polyangiitis (MPA) 446.0 (effective 04/19/11-FDA approval)			
Leg/	Cranial Stereotactic Radiosurgery (SRS)	L30318	RAD-018	07/17/2009

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
MAC	and Cranial Stereotactic Radiotherapy (SRT)			
	ICD-9 codes 146.0-146.9 (Malignant neoplasm of oropharynx) have been added to the policy.			
Leg/ MAC	Stereotactic Computer Assisted Volumetric and/or Navigational Procedure	L29586	GSURG-050	01/01/2011
	<p>Expansion of primary procedures to be used in conjunction with CPT add-on codes 61781, 61782, and 61783. The following procedure codes have been added as primary for the stereotactic computer-assisted (navigational) procedures; *61304, *61305, *61510, *61512, *61514, *61516, *61517, *61592, and *61608. Effective for dates of service 01/01/2011 and thereafter.</p> <p>The following section has been revised and now states the following; Primary Codes: It is the intention of WPS Medicare to reimburse procedures defined as CPT codes 61781, 61782, and 61783 when used in conjunction with most intracerebral procedures, but not routine shunt procedures. When medically reasonable and necessary, the use of a stereotactic guidance system may be reported in addition to the intracranial procedure codes that fall within the range of the following CPT codes: *61304, *61305, *61510, *61512, *61514, *61516, *61517, 61518-61521, 61526-61530, 61541, 61545-61548, *61592, *61608, and 61680-61702.</p> <p>The use of a stereotactic guidance system may be reported in addition to the endoscopic sinus surgery codes that fall within the range 31255-31294 and lateral skull base procedures in appropriately select cases to provide localization and navigation around high-risk anatomical areas when there is documentation of both the medical necessity and the required pre-planning activities.</p> <p>It is required that add-on CPT codes 61781, 61783, and 61783 are billed with a primary code from the lists above. Payment is limited for these add-on codes to the applications of the primary codes discussed in the two paragraphs directly above.</p>			

Electronic Data Interchange (EDI)**ADDITION/DELETION/MODIFICATION OF HPTC CODES -
OCTOBER 2011**

The Healthcare Provider Taxonomy Codes (HPTC) is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available on the Washington Publishing Company (WPC) website at <http://www.wpc-edi.com/codes/taxonomy>

The following additions and/or modifications were made effective October 1, 2011.

Additions

207RH0005X - Under the **Individual** section, **Allopathic & Osteopathic Physicians Type, Internal Medicine Classification** the **Hypertension Specialist Specialization** was added.

A Hypertension Specialist is a physician who concentrates on all aspects of the diagnosis and treatment of hypertension.

Source: American Society of Hypertension

Additional Resources: The American Society of Hypertension Specialists Program offers an examination and designation for Hypertension Specialists.

This subspecialty is not a Board certificate issued by either the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

224Y00000X - Under the **Individual** section, **Respiratory, Developmental, Rehabilitative and Restorative Service Providers Type**, the **Clinical Exercise Physiologist Classification** was added.

A Clinical Exercise Physiologist is a health care professional who is trained to work with patients with chronic disease where exercise training has been shown to be of therapeutic benefit, including but not limited to cardiovascular and pulmonary disease, and metabolic disorders.

Source: What is a Clinical Exercise Physiologist? Clinical Exercise Physiology Association (CEPA), CEPA Executive Board, 2008

335G00000X - Under the **Non-Individual** section, **Suppliers Type**, the **Medical Foods Supplier Classification** was added.

A supplier of special replacement foods for clients with errors of metabolism that prohibit them from eating a regular diet. Medical foods are lacking in the compounds which cause complications of the metabolic disorder, and are not generally available in grocery stores, health food stores, or pharmacies.

Source: The Children with Special Healthcare Needs (CSHCN) Services Program, a program of the Texas Department of State Health Services

Modifications

207L00000X, 207LC0200X, 207LP2900X, 207ND0900X, 207P00000X, 207PS0010X, 207PT0002X, 207QA0000X, 207QG0300X, 207QS0010X, 207R00000X, 207RA0000X, 207RA0201X, 207RA0401X, 207RC0000X, 207RC0001X, 207RC0200X, 207RE0101X, 207RG0100X, 207RG0300X, 207RH0000X, 207RH0003X, 207RI0200X, 207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207U00000X, 207V00000X, 207VC0200X, 207VE0102X, 207VM0101X, 207VX0201X, 207W00000X, 207X00000X, 207XS0106X, 207Y00000X, 207ZB0001X, 207ZF0201X, 207ZH0000X, 207ZM0300X, 207ZN0500X, 207ZP0101X, 207ZP0104X, 207ZP0105X, 208000000X, 2080A0000X, 2080N0001X, 2080P0202X, 2080P0205X, 2080P0207X, 2080P0208X, 2080P0210X, 2080P0214X, 2080S0010X, 208100000X, 2083A0100X, 2083P0901X, 2084A0401X, 2085N0700X, 2085N0904X, 2085P0229X, 2085R0001X, 2085R0202X, 208600000X, 2086S0102X, 2086S0129X

ARE YOU PREPARING FOR 5010?

WPS cannot stress enough the importance that you start early in preparing for implementation of 5010. All covered entities must be ready to submit claims in the 5010 format by January 1, 2012!

5010 implements over 500 changes in content. A gap analysis of new, deleted or modified content between 4010 and 5010 versions needs to be completed. It is important to identify the differences between the current 4010A1 formats and the 5010 formats. This gap analysis will identify changes you may need to make in your business processes. You need to know if your vendor and/or clearinghouse will provide this analysis for you or if you need to conduct the analysis within your organization.

5010 affects the following Business Processes:

- Claims (837 Institutional, Professional, and Dental)
- Claim Status (276/277)
- Claim Payment (835)
- Enrollment (834)
- Premium Payment (820)
- Eligibility (270/271)
- Referrals and Prior Authorizations (278)
- Claims Acknowledgements (277CA)
- Acknowledgement for Health Care Insurance (999)

CMS has some documentation available on their website, which includes a side-by-side comparison of 4010A1 to 5010. Please visit the CMS website:

<http://www.cms.gov/ElectronicBillingEDITrans/Downloads/ProfessionalClaim4010A1to5010.pdf>

CMS is making the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats. The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare Fee-for-Service. Maintenance will be performed without notification, as needed to support Medicare Fee-for-Service.

Medicare fee-for-service is currently updating our claims processing system so that by January 1, 2011, you can begin external testing. Our system will accept claims in both the 4010 and 5010 formats until January 1, 2012.

It is **extremely** important that you communicate with your vendor or clearinghouse about their plans and timeframes for implementing 5010. You need to know where you are on their timeline to ensure you will meet the January 1, 2012 implementation date. You might consider having an alternate plan in place to ensure you are ready for the deadline.

We encourage you to start early, test early, go into production early. If you choose to wait to implement 5010, you may not be able to get the customer service support that you are accustomed to from your payers, vendors or clearinghouses. Your success will depend on starting early! If you fail to prepare, your business and cash flow will be affected!

MEDICARE REMIT EASY PRINT (MREP) AND PC PRINT USER GUIDE UPDATE FOR IMPLEMENTATION OF VERSION 5010A1

~CMS MLN Matters~

MLN Matters® Number:MM7466
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R926OTN

Related Change Request (CR) #: 7466
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) and PC Print software in relation to remittance advices they receive from Medicare contractors (carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs) and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

MREP and PC Print have been updated to include the latest enhancements as part of implementing version 5010A1 for Transaction 835 - Health Care Claim Payment/Advice. Specifically:

- The MREP User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1; and
- The PC Print User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1 version for ASC X12 Transaction 835.

If you use MREP or PC Print, be sure to download the updated user guide for 835 version 5010A1 when they are available.

Background

The Centers for Medicare and Medicaid Services (CMS) is implementing the new standard for Transaction 835 (Health Care Claim Payment/Advice) Version 5010A1 adopted under the Health Insurance Portability and Accountability Act (HIPAA). Providers/Suppliers must transition to the new version on or before January 1, 2012. CMS has made MREP and PC Print software available to providers/suppliers to enable them to view/print/download the electronic remittance advice in version 5010A1 in a human readable format.

Additional Information

The official instruction, CR7466 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R926OTN.pdf> on the CMS website. For more information on the Version 5010 transition and implementation, visit <http://www.cms.gov/Versions5010andD0/> on the CMS website.

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

MODIFICATIONS TO THE IMPLEMENTATION OF THE PAPERWORK (PWK) SEGMENT FOR X12N VERSION 5010 ~ Revised CMS MLN Matters ~

MLN Matters® Number: MM7306 Revised
Related CR Release Date: June 22, 2011

Related Change Request (CR) #: 7306
Effective Date: July 1, 2011, except October 1,
2011, for claims submitted to DME MACs
Implementation Date: July 5, 2011, except October
3, 2011, for claims submitted to DME MACs

Related CR Transmittal #: R908OTN

Note: This article was revised on June 23, 2011, to reflect a revised CR7306, which was issued on June 22. In this article, the effective and implementation dates have been revised for claims handled by DME MACs. Also, the CR release date, transmittal number, and the web address for accessing CR7306 have been revised. All other information is the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 7306, which instructs Medicare contractors about additional business requirements that are necessary to complete the implementation of the PWK segment scheduled for July 2011 (except October 2011 for DME MACs) under CR 7041. An article related to CR 7041 is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf> on the CMS website. Of significance to the provider community is a change whereby Medicare contractors will only return an incomplete/incorrect fax/mail cover sheet, when such is received. In CR 7041, the attached data was to be returned as well, but that is no longer the case. Also, note that CR 7306 requires your contractor to mask any Protected Health Information (PHI) on the fax/cover sheet returned to you.

In addition, the following changes will result from CR 7306:

- In PWK02, Medicare contractors will only use values BM and FX and will communicate that via the companion document. Other values will be accepted only in CMS-approved electronic claims attachment pilots based on agreements with willing trading partners.

- Medicare contractors will have the ability to accept the PWK02 value of EL for those contractors in a CMS-approved electronic claims attachment pilot.
- Contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be submitted when the PWK02 value is EL.

Be sure your staffs are informed of this change.

Additional Information

The official instruction, CR7306, issued to your FI, carrier, A/B MAC, and DME/MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R908OTN.pdf> on the CMS website.

If you have any questions, please contact your 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.

REPORTING OF RECOUPMENT FOR OVERPAYMENT ON THE REMITTANCE ADVICE (RA) WITH PATIENT CONTROL NUMBER ~CMS MLN Matters~

MLN Matters® Number: MM7499
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R940OTN

Related Change Request (CR) #: CR 7499
Effective Date: January 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment MACs (DME 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) 7499 which instructs Medicare’s claims processing systems maintainers to replace the Health Insurance Claim (HIC) number being sent on the ASC X12 Transaction 835) with the Patient Control Number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf> and CR7068 can be reviewed at <http://www.cms.gov/transmittals/downloads/R812OTN.pdf> on the CMS website

It has been brought to the attention of CMS that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the Standard Paper Remit or the 004010A1 version of ASC X12 Transaction 835.

Additional Information

The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R940OTN.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.

General Information**GUIDELINES TO ALLOW CONTRACTORS TO DEVELOP AND UTILIZE PROCEDURES FOR ACCEPTING AND PROCESSING REOPENINGS VIA A SECURE INTERNET PORTAL/APPLICATION**
~CMS MLN Matters~

MLN Matters® Number: MM7420
Related CR Release Date: June 17, 2011
Related CR Transmittal #: R2241CP

Related Change Request (CR) #: CR 7420
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected

Physicians, suppliers, and other providers who bill Medicare Fiscal Intermediaries (FIs), carriers, Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries are affected.

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

Effective October 1, 2011, you may have (depending on your contractor) an alternative, electronic method to submit your requests for Medicare Fee-For-Service (FFS) claim reopenings.

CAUTION – What You Need to Know

CR7420, from which this article is taken (effective October 1, 2011,) allows Medicare contractors to use a secure Internet portal/application to accept and process your requests for reopening Medicare FFS claims.

GO – What You Need to Do

You should make sure that your billing staffs are aware of this change.

Background

In response to requests from Medicare contractors, CR7420 (from which this article is taken) updates the current instructions in the “Medicare Claims Processing Manual” Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), to allow them to accept claimant initiated reopening requests via a secure Internet portal/application – effective October 1, 2011. (You can find this manual at <http://www.cms.gov/manuals/downloads/clm104c34.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.)

Note: Medicare contractors may not require you to file a reopening via a secure Internet portal/application. Also, contractors are not required to offer this electronic capability.

Medicare will have a number of requirements for Medicare contractors utilizing a secure Internet portal/application for reopening. Specifically, to provide this access, contractors will:

- Incorporate a formal registration process that contains validation of the electronic signature on the reopening request, which will include, at a minimum, the use of

restricted user identifiers (IDs) and passwords, and a method for authenticating that the party has completed the portal registration process and has been properly identified by the system as an appropriate user.

- Include, in the appeals case file, an indication and/or description of the validation methodology; should a redetermination and/or higher level of appeal be submitted following an adverse reopening decision.
- Ensure that secure Internet portal/applications developed for reopening activities adhere to the security standards in the Health Insurance and Portability and Accountability Act (HIPAA); and comply with all CMS security requirements regarding protected health information prior to implementation.
- Issue a reopening decision or refusal to reopen via a secure Internet portal/application only if the party has submitted the request for reopening through that application.
- Provide adequate education to participating parties:
 - Regarding system capabilities/limitations prior to implementation and utilization of the secure portal; and
 - Reminding them that participation/enrollment in the secure portal/application is at their discretion and that they bear the responsibility for the authenticity of the information being attested to in the request.
- 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 will include a statement indicating that the document was, “electronically signed by” or “verified/approved by,” etc.
- Ensure that appropriate procedures are in place, via the secure Internet/portal, to provide parties to the reopening with receipt confirmation of the reopening request, and instructions not to submit additional reopening requests for the same item/service via different venue (i.e., telephone, in writing, etc.).
- Consider decisions processed via a CMS approved secure Internet portal/application complete on the date the electronic reopening decision notice is transmitted to the party through the secure Internet portal/application.
- Ensure that there is a process in place by which a party can submit, via the secure application/portal; additional documentation/materials concurrent with the reopening request (i.e. ensure that the portal/application has the capability to accept additional documentation and/or other materials to support the reopening request.)
- Include a mechanism that tracks and marks the date/time of the notification so the submitting party is adequately informed about the timeframes required to ensure timely submission of future appeal requests for the item/service at issue, if applicable; and ensure that parties may save and print the refusal to reopen notice and the adverse revised determination/decision notice.
- Ensure that refusal to reopen and adverse revised determination notices transmitted via a secure Internet portal/application comply with the timeliness and content requirements as outlined in the “Medicare Claims Processing Manual,” Chapter 34.
- Provide hard copy adverse revised determination/decision notices to parties to the reopening who do not have access to the secure Internet portal/application; and ensure that these notices are mailed and/or otherwise transmitted on the same day the notice is transmitted via the secure portal/application.)
- Include the adverse revised determination/decision notice and any other related materials in the appeals case file if a valid appeal on the item/service is later requested.

Contractors will not issue a refusal to reopen notice if they begin processing a valid and timely request for redetermination as a reopening (clerical error or otherwise) and later determine that a reopening cannot be performed, or the determination cannot be changed. Rather, they will process the request as a valid/timely redetermination (as originally requested by the party) in accordance with the “Medicare Claims Processing Manual,” Chapter 29 (Appeals of Claims Decisions), which you can find at <http://www.cms.gov/manuals/downloads/clm104c29.pdf> on the CMS website.

Additional Information

You can find the official instruction, CR7420, issued to your FI or A/B MAC by visiting <http://www.cms.gov/transmittals/downloads/R2241CP.pdf> on the Centers for Medicare & Medicaid (CMS) website.

You will find the updated “Medicare Claims Processing Manual,” Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), Sections 34.10 (Reopenings and Revisions of Claims Determinations and Decisions-General), 34.10.1 (Authority to Conduct a Reopening), 34.10.6.4 (Timeframes When a Party Requests an Adjudicator Reopen Their Decisions), 34.10.7 (Timeframes to Complete a Reopening Requested by a Party), 34.10.8 (Notice of a Revised Determination or Decision), and 34.10.13 (System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities) as an attachment to that CR.

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

RECOVERY AUDIT PROGRAM: MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)-ISSUED DEMAND LETTERS ~CMS MLN Matters~

MLN Matters® Number: MM7436
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R192FM

Related Change Request (CR) #: 7436
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for all physicians, providers, and suppliers who bill Medicare claims processing contractors (Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (MACs)).

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7436 which announces that Medicare’s Recovery Auditors will no longer issue demand letters to you as of January 3, 2012.

CAUTION – What You Need to Know

Recovery Auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the Recovery Auditor’s review, and issue an automated demand letter to you.

GO – What You Need to Do

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

Background

As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any Recovery Auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating Recovery Auditor and his/her contact information in the related demand letter. You should contact that Recovery Auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

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 Centers for Medicare & Medicaid Services (CMS) website.

To see the official instruction (CR7436) issued to your Medicare contractor, see <http://www.cms.gov/Transmittals/downloads/R192FM.pdf> 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****Legacy Providers**

If you are a Legacy Part A provider in the United States and/or U.S. Virgin Islands, who previously contracted with Mutual of Omaha and joined WPS in November 2007, please visit the WPS Medicare Training Programs schedule at

http://www.wpsmedicare.com/part_a/training/training_programs/ to learn more about and to register for the educational events we have scheduled in the upcoming months.

MAC Providers

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 Training Programs 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.

Reimbursement**2012 ANNUAL UPDATE FOR THE HEALTH PROFESSIONAL
SHORTAGE AREA (HPSA) BONUS PAYMENTS**

~CMS MLN Matters~

MLN Matters® Number: MM7517
Related CR Release Date: August 12, 2011
Related CR Transmittal #: R2274CP

Related Change Request (CR) #: 7517
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for physicians and other providers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in Health Professional Shortage Areas (HPSAs).

What You Need to Know

Change Request (CR) 7517, from which this article is taken, alerts providers that the annual HPSA bonus payment file for 2012 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2012, through December 31, 2012. These files will be posted to the internet on or about December 1, 2011. Physician and other providers should review <https://www.cms.gov/hpsapsaphysicianbonuses/> each year to determine whether they need to add the AQ modifier to their claim in order to receive the bonus payment, or a in which they rendered services will automatically receive the HPSA bonus payment. to see if the ZIP code are

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors each year.

Additional Information

The official instruction, CR7517 issued to your carrier, A/B MAC, and FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2274CP.pdf> on the CMS website.

You will find annual HPSA files (as they become available) and other important HPSA information at <https://www.cms.gov/hpsapsaphysicianbonuses/> on the CMS website.

If you have any questions, please contact your carrier, A/B 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.

**ADDITION OF MEDICAL SEVERITY DIAGNOSIS RELATED GROUP
(MS-DRG) 265 TO THE LIST SUBJECT TO INPATIENT
PROSPECTIVE PAYMENT SYSTEM (IPPS) REPLACED DEVICES
OFFERED WITHOUT COST OR WITH A CREDIT POLICY
~CMS MLN Matters~**

MLN Matters® Number: MM7457
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R922OTN

Related Change Request (CR) #: 7457
Effective Date: October 1, 2008
Implementation Date: January 3, 2012

Provider Types Affected

Hospitals submitting claims to Fiscal Intermediaries (FIs) and Parts A/B Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries relating to replaced medical devices are affected by this article.

Provider Action Needed

This article, based on CR 7457, informs you that MS-DRG 265 is being added to the list of DRGs subject to the final policy for the IPPS reimbursement of replaced devices offered without cost or with a credit. Please be sure to inform your billing staffs of this change. In addition, **to expedite processing in view of timely filing edits, please reference CR7457 in the remarks section of applicable claims or adjustments.**

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) was made aware that MS-DRG code 265 was omitted from the list of DRGs subject to the final policy for the IPPS reimbursement of replaced devices offered without cost or with a credit. In FY 2008, both the Automatic Implantable Cardiac Defibrillator (AICD) Generator Procedures and the Lead Procedures were combined in MS-DRG 245. When the MS-DRGs for FY 2009 were created, the AICD Lead Procedures were separated from the generators and grouped to MS-DRG 265.

CR 5860 instructed providers to bill the amount of the credit for a replaced device if the hospital receives a credit that is 50% or greater than the cost of the device effective for discharges on or after October 1, 2008. Medicare will reduce the hospital reimbursement for one of the applicable MS-DRGs listed in that CR by the full or partial credit a provider received for a replaced device as associated with value code "FD." CR 5860 is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM5860.pdf> on the CMS website.

MS-DRG 265, AICD Lead Procedures, is being added to the list in the table below of MS-DRGs subject to the policy for adjusting IPPS reimbursement for replaced devices offered without cost or with a credit.

DRGs Subject to Final Policy		
MDC	MS-DRG	Narrative Description of DRG
PRE	1 & 2	Heart Transplant or Implant of Heart Assist System with and without MCC, respectively (former MS-DRG 103, Heart Transplant or Implant of Heart Assist System)
1	25 & 26	Craniotomy and Endovascular Intracranial Procedure with MCC or

DRGs Subject to Final Policy		
MDC	MS-DRG	Narrative Description of DRG
		with CC, respectively (former CMS-DRG 1, Craniotomy Age > 17 With CC)
1	26 & 27	Craniotomy and Endovascular Intracranial Procedure with CC or without CC/MCC, respectively (former CMS-DRGs 2, Craniotomy Age > 17 Without CC)
1	40 & 41	Peripheral & Cranial Nerve & Other Nervous System Procedure with MCC; or with CC or Peripheral Neurostimulator, respectively (former CMS-DRG, 7 Peripheral & Cranial Nerve & Other Nervous System Procedures With CC)
1	42	Peripheral & Cranial Nerve & Other Nervous System Procedure without CC/MCC (former CMS-DRG 8, Peripheral & Cranial Nerve & Other Nervous System Procedures without CC)
1	23 & 24	Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant; and without MCC [or Chemotherapy Implant], respectively (former CMSDRG 543, Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis)
3	129 & 130	Major Head & Neck Procedures with CC/MCC or Major Device; or without CC/MCC, respectively (former CMS-DRG 49, Major Head & Neck Procedures)
5	216, 217, & 218	Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization With MCC; or with CC; or without CC/MCC, respectively (former CMS-DRG 104, Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization)
5	219, 220, & 221	Cardiac Valve & Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC; or with CC, or without CC/MCC, respectively (former CMS-DRG 105, Cardiac Valve & Other Major Cardiothoracic Procedures Without Cardiac Catheterization)
5	237	Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair (former CMS-DRG 110, Major Cardiovascular Procedures With CC)
5	238	Major Cardiovascular Procedures without MCC (former CMS-DRG 111, Major Cardiovascular Procedures without CC)
5	260, 261, & 262	Cardiac Pacemaker Revision Except Device Replacement with MCC, or with CC, or without CC/MCC, respectively (former CMS-DRGs117, Cardiac Pacemaker Revision Except Device Replacement)
5	258 & 259	Cardiac Pacemaker Device Replacement With MCC, and Without MCC, respectively (former CMS-DRG 118, Cardiac Pacemaker Device Replacement)
5	226 & 227	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC and without MCC, respectively (former CMS-DRG 515, Cardiac Defibrillator Implant without Cardiac Catheterization)
5	215	Other Heart Assist System Implant (former CMS-DRG 525, Other Heart Assist System Implant)
5	222 & 223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart

DRGs Subject to Final Policy		
MDC	MS-DRG	Narrative Description of DRG
		Failure/Shock with MCC and without MCC, respectively (former CMS-DRGs 535, Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock)
5	224 & 225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock with MCC and without MCC, respectively (former CMS-DRG 536, Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock)
5	242, 243, & 244	Permanent Cardiac Pacemaker Implant with MCC, with CC, and without CC/MCC, respectively (MS-DRG 551, Permanent Cardiac Pacemaker Implant with Major Cardiovascular Diagnosis or AICD Lead or Generator)
5	242, 243, & 244	Permanent Cardiac Pacemaker Implant with MCC, with CC, and without CC/MCC, respectively (former CMS-DRG 552, Other Permanent Cardiac Pacemaker Implant without Major Cardiovascular Diagnosis)
5	245	AICD Generator Procedures (this is a new MS-DRG, created from AICD and generator codes moved out of CMS DRG 551)
5	265	AICD Lead procedures
8	461 & 462	Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC, or without MCC, respectively (former CMS-DRG 471, Bilateral or Multiple Major Joint Procedures of Lower Extremity)
8	469 & 470	Major Joint Replacement or Reattachment of Lower Extremity with MCC or without MCC, respectively (former CMS-DRG 544, Major Joint Replacement or Reattachment of Lower Extremity)
8	466, 467, & 468	Revision of Hip or Knee Replacement with MCC, with CC, or without CC/MCC, respectively (former CMS-DRG 545, Revision of Hip or Knee Replacement)

Additional Information

The official instruction, CR 7457, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R922OTN.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.

**AFFORDABLE CARE ACT - SECTION 3113 - LABORATORY
DEMONSTRATION FOR CERTAIN COMPLEX DIAGNOSTIC TESTS –
(CR 7413 FULLY RESCINDS AND REPLACES CR 7278)**

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM7413 Revised
Related CR Release Date: July 15, 2011
Related CR Transmittal #: R2226CP and R74DEMO

Related Change Request (CR) #: 7413
Effective Dates: January 1, 2012
Implementation Date: January 3, 2012

Note: This article was replaced on July 29, 2011 by MLN Matters® article MM7516, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7516.pdf> on the Centers for Medicare & Medicaid Services website.

**AFFORDABLE CARE ACT - SECTION 3113 - LABORATORY
DEMONSTRATION FOR CERTAIN COMPLEX DIAGNOSTIC TESTS
(THIS ARTICLE FULLY RESCINDS AND REPLACES MM7413)**

~ CMS MLN Matters ~

MLN Matters® Number: MM7516
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R78 DEMO and R2261CP

Related Change Request (CR) #: 7516
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

Clinical laboratories and hospitals submitting claims to Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs) for certain complex diagnostic tests provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7516 which announces that the Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning January 1, 2012, or until the one hundred million dollars (\$100,000,000) payment ceiling established by the Affordable Care Act has been reached. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Section 3113 of the Affordable Care Act requires CMS to conduct a demonstration under Part B, title XVIII of the Social Security Act (the Act) for 2 years subject to a \$100 million total payment limit. This demonstration will allow a separate payment to laboratories performing certain complex laboratory tests billed with a Date of Service that would, under standard Medicare rules (at 42 CFR414.510(b)(2)(i)(A)), be bundled into the payment to the hospital or Critical Access Hospital (CAH). Payment under the demonstration begins January 1, 2012. Once the demonstration has ended, payment for these tests will be made under the existing non-demonstration process.

Under the Affordable Care Act (Section 3113), the term “complex diagnostic laboratory test” means a diagnostic laboratory test that is:

- An analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;
- Determined by the Secretary of Health and Human Services to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;
- Billed using a Healthcare Common Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;
- Approved or cleared by the Food and Drug Administration (FDA) or covered under title XVIII of the Social Security Act; and
- Described in Section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). (See http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet)

Section 3113(a)(3) defines separate payment as “direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act [(the Act)] by reason of Sections 1862(a)(14) and 1866(a)(1)(H)(i)” of the Act. In general terms, Sections 1862(a)(14) and 1866(a)(1)(H) of the Act state that no Medicare payment will be made for non-physician services, such as diagnostic laboratory tests, furnished to a hospital or CAH patient unless the tests are furnished by the hospital or CAH, either directly or under arrangement.

The Date of Service (DOS) rule at 42 CFR 414.510(b)(2)(i)(A) defines the date of service of a clinical laboratory test as the date the test was performed only if a test is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital or CAH. When a test is ordered by the patient’s physician less than 14 days following the date of the patient’s discharge from the hospital, the hospital or CAH must bill Medicare for a clinical laboratory test provided by a laboratory and the hospital or CAH would in turn pay the laboratory if the test was furnished under arrangement. Under the demonstration, a laboratory may bill Medicare directly for a complex clinical laboratory test which is ordered by the patient’s physician less than 14 days following the date of the patient’s discharge from the hospital or CAH.

Laboratories choosing to directly bill Medicare under this demonstration must submit a claim with a Project Identifier 56. By submitting a claim with the Section 3113 Demonstration Project Identifier “56,” the laboratory agrees to cooperate with the independent evaluation and the implementation contractors. This may include providing data needed to assess the impact of the demonstration and participating in surveys and/or site visits as requested by these contractors.

Laboratories shall report the Demonstration Project Identifier 56 in item 19 on the CMS 1500 form, in locator 63 on the UB04, on the electronic claim in X12N 837P (HIPAA version) Loop 2300, REF02, REF01=P4 and in X12N 837I (HIPAA version) Loop 2300, REF02, G1 in REF01 DE 128. Claims billed for this demonstration cannot include non-demonstration services on the same claim/bill.

All test codes included in this demonstration will be on the “Section 3113 Demonstration Fee Schedule (also referred to or known as the Demonstration Test List).” This fee schedule will be used to pay for test codes included in the demonstration and billed using the Demonstration Project Identifier 56. Participation in this demonstration is voluntary and available to any laboratory nationwide. There will be no locality variation on the Section 3113 Demonstration Fee Schedule (or Test List). All payments will be made under locality “DE” on the demonstration fee schedule. Changes to the 3113 demonstrations fee schedule, if any, will be made on a prospective basis, and will not be implemented retroactively.

All other Medicare rules for adjudicating laboratory claims continue to apply. For the purpose of CR7516, the period of the 2 year demonstration period is effective for dates of service between January 1, 2012 and December 31, 2013.

Additional Information

The official instruction, CR7516, was issued in two transmittals to your FI, carrier and/or A/B MAC. The first transmittal updates the *Demonstrations Manual* and is at <http://www.cms.gov/Transmittals/downloads/R78DEMO.pdf> on the CMS website. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R2261CP.pdf> on the same site.

If you have any questions, please contact your FI, carrier, and/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.

CRITICAL ACCESS HOSPITAL (CAH) OPTIONAL METHOD ELECTION FOR OUTPATIENT SERVICES ~CMS MLN Matters~

MLN Matters® Number: MM7404
Related CR Release Date: May 27, 2011
Related CR Transmittal #: R2232CP

Related Change Request (CR) #: CR 7404
Effective Date: October 1, 2010
Implementation Date: October 3, 2011

Provider Types Affected

Critical Access Hospitals (CAHs) paid under the optional method election (Method II) submitting claims for outpatient services to Fiscal Intermediaries (FI) and A/B Medicare Administrative Contractors (A/B MAC) are affected by this article.

What You Need to Know

Prior to a change made in the Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) final rule, if a CAH chose to be paid under the optional method (Method II), it was required to make that election on an annual basis.

However, in the FY 2011 IPPS final rule, the Centers for Medicare & Medicaid Services (CMS) changed the regulations for the optional method election.

- Effective for cost reporting periods beginning on or after October 1, 2010, if you elected the optional method in your most recent cost reporting period beginning before October

1, 2010, that election remains in place until you submit a termination request to your FI or A/B MAC. You will no longer be required to make an annual election.

- Effective for cost reporting periods beginning on or after October 1, 2010, if you had not elected the optional method in your most recent cost reporting period beginning before October 1, 2010, and wish to elect the optional method or you had elected that method in your most recent cost reporting period beginning before October 1, 2010, but had terminated that election, and you wish to re-elect the optional method, that election remains in place until you submit a termination request to your FI or A/B MAC. You will no longer be required to make an annual election.
- Effective for cost reporting periods beginning on or after October 1, 2010, if you choose to terminate your optional method election, you must submit a termination request to your FI or A/B MAC at least 30 days prior to the start of the next cost reporting period.
- Effective for cost reporting periods beginning on or after October 1, 2010, if you had not been paid under the optional method in your most recent cost reporting period beginning before October 1, 2010, or had been paid using the optional method in your most recent cost reporting period beginning before October 1, 2010, but had terminated that election, and you choose to be paid under the optional method on or after October 1, 2010, you must make this election in writing and that election must be delivered to your FI or A/B MAC at least 30 days before the start of the first cost reporting period for which the election is effective.

Please be sure that your staffs are aware of these changes.

Background

CAHs can be paid for outpatient services using either the standard method (also referred to as “Method I”) or the optional method (also referred to as “Method II”). Under the standard method, the physician or practitioner is paid under the physician fee schedule for the professional service by their carrier or A/B MAC whereas, under the optional method, the physician or practitioner reassigns his or her billing rights to the CAH and the CAH is paid 115 percent of the physician fee schedule amount for the professional service by the FI or A/B MAC. Under both methods, facility services are reimbursed at 101 percent of reasonable cost.

Additional Information

The official instruction, CR7404 issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2232CP.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.

**IMPLEMENTATION OF THE MEDICARE IMPROVEMENTS FOR
PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA) 153C END
STAGE RENAL DISEASE (ESRD) QUALITY INCENTIVE PROGRAM
(QIP) AND OTHER REQUIREMENTS FOR ESRD CLAIMS
~CMS MLN Matters~**

MLN Matters® Number: MM7460
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R2262CP

Related Change Request (CR) #: CR 7460
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for End Stage Renal Disease (ESRD) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7460 which announces the implementation of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section 153c) End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and other requirements for ESRD claims.

CAUTION – What You Need to Know

MIPPA (Section 153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement an ESRD Quality Incentive Program (QIP) effective January 1, 2012, that will result in payment reductions to providers of services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures.

GO – What You Need to Do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section 153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement a quality based payment program for dialysis services with payment consequences effective January 1, 2012. This QIP will result in payment reductions to providers of ESRD services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures. The ESRD QIP is the first Medicare program which will link payments to performance based on outcomes as assessed through specific quality measures.

These measures are defined in the annual Dialysis Facility Report (DFR) that each provider receives in addition to the final rule. The payment reductions will:

- Apply to payment for renal dialysis services furnished on or after January 1, 2012;
- Be up to 2.0 percent of payments otherwise made to ESRD facilities;
- Apply only to the year involved for an ESRD facility; and

- Not be taken into account when computing future payment rates for the impacted facility.

In addition to implementing the QIP, CMS will require ESRD facilities to provide the following on **ALL** ESRD claims with dates of service on or after January 1, 2012:

- The hemoglobin and/or hematocrit value(s);
- The route of administration of Erythropoiesis Stimulating Agents (ESAs) using the JA or JB modifier code for any claim indicating the administration of ESAs;
- The Kt/V (calculated using a specified formula) indicating the measurement of dialysis adequacy.

Note: Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081 or J0882 on a 72X type of bill will result in that bill being returned to the provider.

CMS is making these changes to assess:

- The management of anemia for ESRD patients;
- The safety of the administration of ESAs; and
- The adequacy of the dialysis provided to ESRD patients using a standardized methodology for the calculation of Kt/V.

These changes will enable CMS to meet the intent of the MIPPA (Section 153c) legislation to monitor safety and outcomes delivered by ESRD providers for the entire ESRD population as part of the QIP. QIP reductions, where appropriate, will be applied to ESRD PPS payments (and composite rate portion of the payment for transitioning providers). In addition, any QIP reduction will also apply to ESRD related separately billable services for ESRD facilities under the ESRD PPS transitional payment through December 31, 2013.

Reporting Hemoglobin and/or Hematocrit:

CMS will require the submission of the most recent hemoglobin or hematocrit lab value taken prior to the start of the billing period on all ESRD claims irrespective of ESA administration. **Failure to submit a hemoglobin and/or hematocrit value on all ESRD claims will adversely impact a facility's QIP score and public reporting on Dialysis Facility Compare (DFC).**

Required Reporting for ESA Route of Administration:

When reporting the administration of ESAs, CMS will require the reporting of modifiers JA (intravenous administration) or JB (subcutaneous administration) indicating the route of administration on all ESRD claims with dates of service on or after January 1, 2012.

ESRD claims that do not contain modifier JA or JB (when ESA administration is indicated) will be returned to the provider for correction. Patients with ESRD receiving administrations of ESAs (such as epoetin alfa (EPO) and Darbepoetin alfa (Aranesp)) for the treatment of anemia may receive intravenous administration or subcutaneous administrations of the ESA. Existing instructions require that ESRD facilities submit each administration on a separate line item. Renal dialysis facility claims including administrations of the ESAs by both methods must report the appropriate route of administration for each line item.

Calculation of the Kt/V Value:

CMS will require the use of the following Kt/V calculations based on the dialytic modality when entering Value Code D5 on ESRD claims:

- **Hemodialysis:** For in-center and home-hemodialysis patients prescribed for three or fewer treatments per week, the Kt/V must be reported for the last dialysis session covered by the claim, each month. Facilities must report single pool Kt/V using the following preferred National Quality Forum (NQF) endorsed methods for deriving the single pool Kt/V value:
 - Daugirdas 2, or
 - Urea Kinetic Modeling (UKM).

For patients routinely prescribed four or more hemodialysis treatments per week, a value of 8.88 should be entered on the claim; however, the 8.88 value should not be used for patients who are receiving “extra” treatments for temporary clinical need.

- **Peritoneal Dialysis:** When measured, the delivered weekly total Kt/V (dialytic and residual) should be reported.

Note: All other requirements associated with ESRD claims will remain unchanged.

Additional Information

The official instruction, CR7460, issued to your FI or A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2262CP.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.

**INPATIENT REHABILITATION FACILITY (IRF) ANNUAL UPDATE:
PROSPECTIVE PAYMENT SYSTEM (PPS) PRICER CHANGES FOR
FISCAL YEAR (FY) 2012
~CMS MLN Matters~**

MLN Matters® Number: MM7510
Related CR Release Date: August 12, 2011
Related CR Transmittal #: R2275CP

Related Change Request (CR) #: 7510
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected

This article is for Inpatient Rehabilitation Facilities (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) 7510 which provides updated rates used to correctly pay Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) claims for Fiscal Year (FY) 2012. Be sure your billing staff is aware of these changes.

Key Points of CR7510

The FY 2012 IRF PPS Update Notice published on July 29, 2011, 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, 2011, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2011, through September 30, 2012.

PRICER Updates: For IRF PPS FY 2011 (October 1, 2011 – September 30, 2012)

- The standard Federal rate is \$14,076;
- The fixed loss amount is \$10,660;
- The labor-related share is 0.70199;
- The non-labor related share is 0.29801;
- Urban national average Cost-to-Charge Ratio (CCR) is 0.520;
- Rural national average CCR is 0.669;
- The Low Income Patient (LIP) Adjustment is 0.4613;
- The Teaching Adjustment is 0.6876; and
- The Rural Adjustment is 1.184.

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 (CR7510) issued to your Medicare MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R2275CP.pdf> on the CMS website.

JULY 2011 UPDATE OF THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

~CMS MLN Matters~

MLN Matters® Number: MM7443
Related CR Release Date: May 27, 2011
Related CR Transmittal #: R2234CP

Related Change Request (CR) #: CR 7443
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected

This article is for providers submitting claims to Medicare Contractors (Fiscal Intermediaries (FIs), 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 Outpatient Prospective Payment System (OPPS).

Provider Action Needed

This article is based on Change Request (CR) 7443 which describes changes to and billing instructions for various payment policies implemented in the July 2011 OPSS update. The July 2011 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 this Change Request (CR). Be sure your billing staffs are aware of these changes.

Background

Change Request (CR) 7443 describes changes to and billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR7443. The July 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR7439, "July 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.2." The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM7439.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key OPPS Updates for July 2011

Changes to Device Edits for July 2011

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.

New Services

The following new services are assigned for separate payment under the OPPS, effective July 1, 2011:

Table 1 -- New Services Assigned for Separate Payment under the OPPS Effective July 1, 2011

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9730	7/1/2011	T	0415	Bronchial thermo, 1 lobe	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 1 lobe	\$1,971.77	\$459.92

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9731	7/1/2011	T	0415	Bronchial thermo, >1 lobe	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 2 or more lobes	\$1,971.77	\$459.92

Effective July 1, 2011, HCPCS code C9729 will be deleted and replaced with new Category III Current Procedural Terminology (CPT) code 0275T. Category III CPT code 0275T will be added to the payable codes in the OPSS and assigned to the same status indicator and APC assignment as its predecessor HCPCS code C9729. Providers reporting the intralaminar decompression procedure should use CPT code 0275T beginning with services rendered on or after July 1, 2011. The table below summarizes the new coding information.

Table 2 -- Coding Change for the Intralaminar Decompression Procedure Effective July 1, 2011

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9729	7/1/2011	Deleted	Deleted	Percut lumbar lami	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed,	N/A	N/A

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
					single or multiple levels, unilateral or bilateral; lumbar		
0275T	7/1/2011	T	0208	Perq lamot/lam lumbar	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	\$3,535.92	\$707.19

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 Calendar Year (CY) 2006, CMS implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), CMS modified their process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and

some of the C-codes that are payable under the OPPS and were created by CMS in response to applications for new technology services.

For the July 2011 update, CMS is implementing in the OPPS 14 Category III CPT codes that the AMA released in January 2011 for implementation on July 1, 2011. Of the 14 Category III CPT codes, 12 are separately payable under the hospital OPPS. The Category III CPT codes, status indicators, and APCs are shown in Table 3 below. Payment rates for these services can be found in Addendum B of the July 2011 OPPS Update that is posted on the CMS website.

Table 3 -- Category III CPT Codes Implemented as of July 1, 2011

CPT Code	Long Descriptor	SI	APC
0262T	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach	C	NA
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	S	0112
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	S	0112
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	S	0112
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	C	NA
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	T	0687
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	S	0039
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	T	0221
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	T	0687

CPT Code	Long Descriptor	SI	APC
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	T	0688
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)	S	0218
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming	S	0218
0274T	Percutaneous laminotomy/laminectomy (intradiscal approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic	T	0208
0275T	Percutaneous laminotomy/laminectomy (intradiscal approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	T	0208

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 an item described by a reported HCPCS code 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 OPDS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399.

HCPCS code C9399, “Unclassified drug or biological,” is only for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, and for which a specific HCPCS code has not been assigned.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead cost associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, 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 cost of these pass-through items. CMS notes that for the third quarter of CY 2011, 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, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals that are a part of the Part B drug CAP program, as required by the statute.

In the CY 2011 OPPTS/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 2011 release of the OPPTS Pricer. The updated payment rates, effective July 1, 2011, will be included in the July 2011 update of the OPPTS Addendum A and Addendum B, which will be posted on the CMS website. The Addendums are at <http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS website.

b. Drugs and Biologicals with OPPTS Pass-Through Status Effective July 1, 2011

Seven drugs and biologicals have been granted OPPTS pass-through status effective July 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 4 below.

Table 4 -- Drugs and Biologicals with OPPTS Pass-Through Status Drugs and Biologicals with OPPTS Pass-Through Status Effective July 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/11
C9283*	Injection, acetaminophen, 10 mg	9283	G
C9284*	Injection, ipilimumab, 1 mg	9284	G
C9285*	Lidocaine 70 mg/tetracaine 70 mg, per patch	9285	G
C9365*	Oasis Ultra Tri-Layer Matrix, per square centimeter	9365	G
C9406*	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	9406	G

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/11
J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g. liquid), 500 mg	0947	G
Q2044*	Injection, belimumab, 10 mg	1353	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2011.

c. New HCPCS Codes Effective July 1, 2011, for Certain Drugs and Biologicals

Three new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed above in Table 4) in the hospital outpatient setting for July 1, 2011. These codes are listed in Table 5 below and are effective for services furnished on or after July 1, 2011. HCPCS code Q2041 is replacing HCPCS code J7184 beginning on July 1, 2011, and HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011.

Table 5 -- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/11
Q2041	Injection, von willebrand factor complex (human), Wilate, 1 i.u. vwf:rc0	1352	G
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	1354	K
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	9273	G

Supplemental Information on HCPCS code Q2043 (Provenge)

HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011. In CR 7117, Transmittal 2050, dated September 17, 2010, CMS clarified the reporting of HCPCS code C9273. Since HCPCS code Q2043 is a replacement code for HCPCS code C9273, the reporting instructions for HCPCS code C9273 also apply to HCPCS code Q2043. That is, the language in the long descriptor of HCPCS code Q2043 that states "all other preparatory procedures" refers to the entire process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, sending the immune cells to the facility that prepares the immunotherapy product, and then transporting the immune cells back to the site of service to be administered to the patient.

d. Updated Payment Rate for HCPCS Code J2505 Effective April 1, 2010, through June 30, 2010

The payment rate for HCPCS code J2505 was incorrect in the April 2010 OPSS Pricer. The corrected payment rate is listed in Table 6 below and has been installed in the July 2011 OPSS Pricer, effective for services furnished on April 1,

2010, through implementation of the July 2010 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after April 1, 2010, but prior to July 1, 2010, contain HCPCS Code J2505, and were originally processed prior to the installation of the July 2011 OPSS Pricer.

Table 6 -- Updated Payment Rates for HCPCS Code J2505 Effective April 1, 2010 through June 31, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,386.39	\$477.28

e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010

The payment rates for several HCPCS codes were incorrect in the July 2010 OPSS Pricer. The corrected payment rates are listed in Table 7 below and have been installed in the July 2011 OPSS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after July 1, 2010, but prior to October 1, 2010, contain a HCPCS Code from Table 7, and were originally processed prior to the installation of the July 2011 OPSS Pricer.

Table 7 -- Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	\$11.47	\$2.29
J2430	K	0730	Pamidronate disodium /30 MG	\$15.12	\$3.02
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,423.91	\$484.78
J9065	K	0858	Inj cladribine per 1 MG	\$25.61	\$5.12
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$2.19	\$0.44
J9200	K	0827	Floxuridine injection	\$34.99	\$7.00
J9206	K	0830	Irinotecan injection	\$3.36	\$0.67
J9208	K	0831	Ifosfomide injection	\$29.83	\$5.97
J9209	K	0732	Mesna injection	\$4.15	\$0.83

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9211	K	0832	Idarubicin hcl injection	\$41.14	\$8.23
J9263	K	1738	Oxaliplatin	\$4.35	\$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$44.38	\$8.88

f. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010, through December 31, 2010

The payment rates for several HCPCS codes were incorrect in the October 2010 OPPS Pricer. The corrected payment rates are listed in Table 8 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on October 1, 2010, through implementation of the January 2011 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after October 1, 2010, but prior to January 1, 2011, contain a HCPCS Code from Table 8, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 8 -- Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010 through December 31, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	\$9.59	\$1.92
J2430	K	0730	Pamidronate disodium /30 MG	\$11.81	\$2.36
J9065	K	0858	Inj cladribine per 1 MG	\$24.97	\$4.99
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$9.17	\$1.83
J9185	K	0842	Fludarabine phosphate inj	\$158.16	\$31.63
J9200	K	0827	Floxuridine injection	\$32.17	\$6.43
J9206	K	0830	Irinotecan injection	\$4.68	\$0.94
J9208	K	0831	Ifosfomide injection	\$31.54	\$6.31
J9209	K	0732	Mesna injection	\$4.62	\$0.92
J9211	K	0832	Idarubicin hcl injection	\$84.06	\$16.81
J9263	K	1738	Oxaliplatin	\$4.60	\$0.92
J9266	K	0843	Pegaspargase injection	\$2,675.40	\$535.08

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$33.48	\$6.70

g. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2011, through March 31, 2011

The payment rates for several HCPCS codes were incorrect in the January 2011 OPPS Pricer. The corrected payment rates are listed in Table 9 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2011, but prior to April 1, 2011, contain a HCPCS Code from Table 9, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 9 -- Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2011 through March 31, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9065	K	0858	Inj cladribine per 1 MG	\$24.93	\$4.99
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$1.90	\$0.38
J9200	K	0827	Floxuridine injection	\$37.92	\$7.58
J9206	K	0830	Irinotecan injection	\$5.31	\$1.06
J9208	K	0831	Ifosfomide injection	\$33.40	\$6.68
J9211	K	0832	Idarubicin hcl injection	\$118.41	\$23.68
J9265	K	1309	Paclitaxel injection	\$6.95	\$1.39
J9266	K	0843	Pegaspargase injection	\$2,701.13	\$540.23
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$33.36	\$6.67

h. 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 OPPS payment for the biological is packaged into the payment for the associated procedure.

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

i. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient; hospitals 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,” Pub.100-04, 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.

j. 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 OPSS 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 expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPSS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under the Social Security Act (section 1861(w)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet), and as discussed in 42 CFR 410.28(a)(1) (see http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr410.28.pdf on the Internet) and defined in 42 CFR 409.3 (see http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr409.3.pdf on the Internet), where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

k. Use of HCPCS Code C9399

As stated in the “Medicare Claims Processing Manual,” Pub. 100-04, Chapter 17, Section 90.3 (see <http://www.cms.gov/manuals/downloads/clm104c17.pdf> on the CMS website), hospitals are to report HCPCS code C9399, Unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004 and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not

been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in the "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15, Section 50.2 (see <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the CMS website).

Reporting Hours of Observation

Under current OPPS payment policy, observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). CMS is revising billing instructions to state that in situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services. CMS is updating the "Medicare Claims Processing Manual," Pub.100-04, Chapter 4, Section 290.2.2 (which is included as an attachment to CR7443) to reflect the revised observation reporting guidelines.

Reporting Critical Care Services under the OPPS

Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care (CPT codes 99291 and 99292). CMS continues to recognize the existing CPT codes for critical care services and has established a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

Effective January 1, 2011, National Correct Coding Initiative edits for the hospital OPPS that disallow the reporting of critical care services with ancillary services will be deleted retroactive to January 1, 2011. The I/OCE generates Correct Coding Initiative (CCI) edits for OPPS hospitals. Providers whose claims contained lines that were denied or rejected due to the critical care CCI edits for ancillary services from January 1, 2011, through June 30, 2011, may request contractor adjustment of the previously processed claims.

Payment Window for Outpatient Services Treated as Inpatient Services

The payment window for outpatient services treated as inpatient services policy, specifically described in Transmittal 796, CR7142, issued on October 29, 2010, (see the corresponding MLN Matters article for CR7142 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7142.pdf> on the CMS website), states that a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses,

procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services provided during the payment window. Hospitals may attest to specific non-diagnostic services as being unrelated to the inpatient stay (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding condition code 51 (definition "51 – Attestation of Unrelated Outpatient Non-diagnostic Services) to the separately billed outpatient non-diagnostic services claim starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010.

CMS is adding section 10.12 to the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4, (which is included as an attachment to CR7443) to reflect the regulatory and statutory policy changes outlined in CR7142. CMS is also revising section 180.7 of the *Claims Processing Manual*, Pub. 100-04, Chapter 4, (which is included as an attachment to CR7443) to clarify that CMS will not pay for "inpatient-only" procedures that are provided to a patient in the outpatient setting on the date of the patient's inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission.

Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery

CMS is updating the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4, Section 200.3.4 (which is included as an attachment to CR7443) to correct a typographical error citing HCPCS code G0039 rather than G0339.

Changes to OPPS Pricer Logic

- a. Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The 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 Social Security Act, as added by Section 411 of Pub. L. 108-173. However, the rural SCH and EACH 7.1 percent payment increase does not apply to services billed on a non-patient bill type 014X.
- b. Effective for claims with a date of service on or after January 1, 2011, the OPPS Pricer will not apply Deductible and Coinsurance amounts for Preventive care services waived by Section 4104 of the Patient Protection and Affordable Care Act (the Affordable Care Act) as appropriate.

Additional Items

Medicare contractors will adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2011, but prior to July 1, 2011, include CPT codes 99291 and/or 99292, and were originally processed prior to the installation of the revised July 2011 I/OCE.

Medicare contractors will also adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2006, but prior to July 1, 2011, where the provider is a rural Sole-Community Hospital that received the 7.1% add-on for

laboratory services, contain a type of bill 14X, and were originally processed prior to the installation of the revised July 2011 I/OCE.

Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (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, CR7443, issued to your FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2234CP.pdf> on the CMS website.

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

JULY QUARTERLY UPDATE FOR 2011 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) FEE SCHEDULE

~CMS MLN Matters~

MLN Matters® Number: MM7416
Related CR Release Date: June 3, 2011

Related Change Request (CR) #: 7416
Effective Date: January 1, 2011, for fee schedule amounts for codes effective on that date; otherwise July 1, 2011
Implementation Date: July 5, 2011

Related CR Transmittal #: R2236CP

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 (RHHs)) 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 Change Request (CR) 7416 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) 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 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 CMS website.

Key Points of CR7416

Fees Added

The July Quarterly Update for the 2011 DMEPOS Fee Schedule Part B files established fee schedule amounts for Healthcare Common Procedure Coding System (HCPCS) codes A7020, E1831, and L5961, effective for claims with dates of service on or after January 1, 2011.

Note: Claims for codes A7020, E1831, and L5961 with dates of service on or after January 1, 2011, that were previously processed may be adjusted to reflect the newly established fees if you bring those claims to your contractor’s attention.

Temporary “K” Codes

The following new K codes will be added to contractor’s system effective for dates of service July 1, 2011:

- K0743 – SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

Note: The addition of these codes does not imply any health insurance coverage. Medicare contractors will follow their normal processes in determining whether sufficient evidence exists to determine if these items are reasonable and necessary and covered under Medicare.

Code Updates

- HCPCS code E0571 (AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER) will be made invalid for Medicare claims, effective July 1, 2011.
- The payment category for HCPCS code A4619 (FACE TENT) is being revised as part of this quarterly update to move this nebulizer accessory from the DME payment category for oxygen and oxygen equipment to the DME payment category for inexpensive or other routinely purchased items, effective July 1, 2011. The DMEPOS fee schedule file will be updated to reflect this change.

Payment for Oxygen Contents

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. After the 36-month rental payment period (cap), separate payment may be made for oxygen contents for the remainder of the equipment’s reasonable useful lifetime. However, separate payment for oxygen contents ends when replacement stationary oxygen equipment is furnished causing a new 36-

month rental payment period to begin. Also, separate oxygen contents payment is allowable for beneficiary-owned stationary or portable gaseous or liquid oxygen equipment. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for the stationary oxygen equipment (codes E0424, E0439, E1390, or E1391), a supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Oxygen Equipment Furnished in Month 36	Monthly Contents Payment after the Stationary Cap
Oxygen Concentrator (E1390, E1391, or E1392)	None
Portable Gaseous or Liquid Transfilling Equipment (K0738 or E0433)	None
E0424 Stationary Gaseous System	E0441 Stationary Gaseous Contents
E0439 Stationary Liquid System	E0442 Stationary Liquid Contents
E0431 Portable Gaseous System	E0443 Portable Gaseous Contents
E0434 Portable Liquid System	E0444 Portable Liquid Contents

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0433 or E0444) may begin following the stationary oxygen equipment payment cap AND before the end of the portable equipment cap (E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable equipment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparable damaged). **Under no circumstances would monthly payment be made for both stationary oxygen equipment and either stationary or portable oxygen contents.**

Proof-of-Delivery Requirements for Oxygen Contents

Following the oxygen equipment payment cap, oxygen content billing should be made on the anniversary date of the oxygen equipment billing.

At all times, the supplier is responsible for ensuring that the beneficiary has a sufficient quantity of oxygen contents and is never in danger of running out of contents. A

maximum of 3 months of oxygen contents can be delivered to the beneficiary at one time and billed on a monthly basis. In these situations, the delivery date of the oxygen contents does not have to equal the date of service (anniversary date) on the claim, but in order to bill for contents for a specific month (i.e. the second or third month in the three month period), the supplier must have delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, which may be less than monthly within the three month period. **If the supplier delivers more than one month of oxygen contents at a time (2 to 3), the supplier is not entitled to payment for additional months 2 and 3 if medical need ceases before the date when the supplier would be entitled to bill for those months.**

Payment for Replacement of Equipment After Repairs

Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, Medicare contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

Furthermore, 42 CFR 424.57(14) requires a DMEPOS supplier to maintain or replace a Medicare-covered item it has rented to beneficiaries to its intended status after being repaired. Recent cases have arisen whereupon after multiple repairs, the item continues to malfunction. CR7416 instructs your Medicare contractor to be aware of and educate suppliers of these regulatory requirements to replace DME items for which repairs have not restored the item. Also, after receipt of multiple repair claims, contractors will investigate suspicious claims for replacement equipment billed with its HCPCS code and the RA modifier.

Additional Information

If you have any questions, please contact your Medicare Carrier, DME MAC, 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 associated with this CR7416 issued to your Medicare Carrier, FI, DME MAC, RHHI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2236CP.pdf> on the CMS website.

JULY UPDATE TO THE CY 2011 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB) ~CMS MLN Matters~

MLN Matters® Number: MM7430
Related CR Release Date: May 20, 2011
Related CR Transmittal #: R2223CP

Related Change Request (CR) #:7430
Effective Date: January 1, 2011
Implementation Date: July 5, 2011

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) 7430, which provides the July 2011 update of the payment files that were issued to Medicare contractors based on the 2011 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 (RVUs) for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2011 MPFS Final Rule. CR 7430 amends those payment files. CR 7430 provides corrections, effective for dates of service on or after January 1, 2011, (unless otherwise noted) to those files. These changes include the following:

The following HCPCS codes have MPFSDB indicator changes:

HCPCS Code	Short Descriptor	Indicator	Effective Date
22212	Revision of thorax spine	Co-Surgeons: 1	January 1, 2011
22222	Revision of thorax spine	Co-Surgeons: 1	January 1, 2011
31233	Nasal/sinus endoscopy dx	Assistant at Surgery: 0	January 1, 2011
31235	Nasal/sinus endoscopy dx	Assistant at Surgery: 0	January 1, 2011
64561	Implant neuroelectrodes	Bilateral Surgery: 1	January 1, 2011
74176 TC	Ct abd & pelvis	Physician Supervision of Diagnostic Procedures:01	January 1, 2011
J7184	Wilate injection	Procedure Status Code: I	July 1, 2011

The following HCPCS codes have short descriptor changes:

HCPCS Code	Short Descriptor	Effective Date
0251T	Remov bronchial valve	January 1, 2011
0252T	Remov bronch valve addl	January 1, 2011
22551	Neck spine fuse&remov bel c2	January 1, 2011
22900	Exc abdl tum deep < 5 cm	January 1, 2011
22901	Exc abdl tum deep > 5 cm	January 1, 2011
65779	Cover eye w/membrane suture	January 1, 2011
74176	Ct abd & pelvis	January 1, 2011
74176 TC	Ct abd & pelvis	January 1, 2011
74176 26	Ct abd & pelvis	January 1, 2011
74177	Ct abd & pelv w/contrast	January 1, 2011
74177 TC	Ct abd & pelv w/contrast	January 1, 2011
74177 26	Ct abd & pelv w/contrast	January 1, 2011
74178	Ct abd & pelv 1/> regns	January 1, 2011
74178 TC	Ct abd & pelv 1/> regns	January 1, 2011
74178 26	Ct abd & pelv 1/> regns	January 1, 2011

HCPCS Code	Short Descriptor	Effective Date
88177	Cytp fna eval ea addl	January 1, 2011
88177 TC	Cytp fna eval ea addl	January 1, 2011
88177 26	Cytp fna eval ea addl	January 1, 2011
99218	Initial observation care	January 1, 2011

The following HCPCS codes will be added to the MPFS:

Please note, more information on HCPCS “T” code additions listed below will be found in CR 7443, July 2011 Update of the Hospital Outpatient Prospective Payment System, when it is released. (An article will be available at

<http://www.cms.gov/MLN MattersArticles/downloads/MM7443.pdf> upon release of the CR.)

More information on HCPCS “J” and “Q” code additions listed below can be found in CR 7303, Quarterly HCPCS Drug/Biological Code Changes-July 2011 Update. (An article will be available for that CR at <http://www.cms.gov/MLN MattersArticles/downloads/MM7303.pdf> on the CMS website.) Additionally, policy and instructions on HCPCS Code Q2043 are addressed in CR 7431, Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer. Upon release of CR 7431, an article will be available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7431.pdf> on the CMS site.

HCPCS Code	Short Descriptor	Effective Date
0262T	Impltj pulm vlv evasc appr	July 1, 2011
0263T	Im b1 mrw cel ther cml	July 1, 2011
0264T	Im b1 mrw cel ther xcl hrvt	July 1, 2011
0265T	Im b1 mrw cel ther hrvt onl	July 1, 2011
0266T	Implt/rpl crtd sns dev total	July 1, 2011
0267T	Implt/rpl crtd sns dev lead	July 1, 2011
0268T	Implt/rpl crtd sns dev gen	July 1, 2011
0269T	Rev/remvl crtd sns dev total	July 1, 2011
0270T	Rev/remvl crtd sns dev lead	July 1, 2011
0271T	Rev/remvl crtd sns dev gen	July 1, 2011
0272T	Interrogate crtd sns dev	July 1, 2011
0273T	Interrogate crtd sns w/pgrmg	July 1, 2011
0274T	Perq lamot/lam crv/thrc	July 1, 2011
0275T	Perq lamot/lam lumbar	July 1, 2011
Q2041	Wilate injection	July 1, 2011
Q2042	Hydroxyprogesterone caproate	July 1, 2011
Q2043	Sipuleucel-T auto CD54+	July 1, 2011
Q2044	Belimumab injection	July 1, 2011

Additional Information

In addition to the above, the Attachment of CR7430 contains the long descriptors and all indicators relative to the new HCPCS codes in the preceding table. CR 7430 can be viewed at <http://www.cms.gov/Transmittals/downloads/R2223CP.pdf> the CMS website.

Note: 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.

If you have any questions, please contact your carrier, FI, A/B 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.

METHOD OF COST SETTLEMENT FOR INPATIENT SERVICES FOR RURAL HOSPITALS PARTICIPATING UNDER DEMONSTRATION AUTHORIZED BY SECTION 410A OF THE MEDICARE MODERNIZATION ACT. SECTIONS 3123 AND 10313 OF THE AFFORDABLE CARE ACT AUTHORIZED AN EXPANSION OF THE DEMONSTRATION AND AN EXTENSION FOR AN ADDITIONAL 5-YEAR PERIOD. THIS CHANGE REQUEST (CR) GIVES INSTRUCTIONS FOR THIS ADDITIONAL 5-YEAR PERIOD. THIS CR IS AN EXTENSION OF CR5020 FOR THIS ADDITIONAL 5-YEAR PERIOD

~CMS MLN Matters~

MLN Matters® Number: MM7505
Related CR Release Date: July 22, 2011
Related CR Transmittal #: R77DEMO

Related Change Request (CR) #: 7505
Effective Date: January 1, 2010
Implementation Date: August 22, 2011

Provider Types Affected

This article is for specific rural Inpatient Acute Care hospitals (see list of provider numbers below) that bill Medicare contractors (Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

If you are an affected hospital, make sure your billing and reimbursement staffs are aware of these changes.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated a demonstration that establishes rural community hospitals. An eligible hospital is located in a rural area, has fewer than 51 acute care beds, makes available 24-hour emergency services, and is not eligible for Critical Access Hospital designation. As of November 2010, out of 18 hospitals chosen between 2004 and 2008, 8 hospitals were still participating in the demonstration. Holy Cross Hospital in Taos, NM is withdrawing, effective with its cost report ending on May 31, 2011. Its participation in the continuation period will be effective for the cost report year June 1, 2010 – May 31, 2011.

Sections 3123 and 10313 of the Affordable Care Act both expanded and extended the demonstration. Hospitals continuing participation from the initial period are grandfathered into the project – with a 5-year continuation period for each hospital.

In addition, 18 new hospitals will begin the demonstration. Each will participate for a period of 5 years, beginning on its first cost report start date on or after April 1, 2011. The period of performance will conclude December 31, 2016.

Key Points

For each participating hospital:

1. In the first cost reporting period (the first cost reporting period starting in Calendar Year (CY) 2010 for continuing hospitals, the first cost reporting period on or after April 1, 2011, for newly participating hospitals), the hospital's payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be the reasonable cost of providing such services. Swing bed services are included among the covered services for which the hospital receives payment on the basis of reasonable costs.
2. Reimbursement for the reasonable cost of services to beneficiaries is made according to the principles stated in 42 CFR 413 and Chapter 21 of Part I of the "Provider Reimbursement Manual." As stated in these documents, only costs that can be directly attributed to patient care will be reimbursed.
3. One hundred percent of bad debt will be included in the determination of reasonable cost.
4. Capital costs will be included in the determination of reasonable cost.
5. Costs of outpatient services performed within 72 hours prior to inpatient admission will be bundled, as appropriate, as part of the cost of the inpatient service.
6. The reasonable cost payment for the first cost reporting period applies to the first cost reporting period starting in CY 2010 for the 8 hospitals continuing from the initial demonstration period. It applies to the first cost reporting period on or after April 1, 2011, for the 18 newly participating hospitals.
7. In subsequent cost reporting periods of the demonstration program, payment for covered inpatient services is the lesser of reasonable costs of providing such services or the target amount. This methodology applies to all 26 participating hospitals.
8. The payment methodology for covered inpatient services during subsequent cost reporting periods, i.e., Years 2 through 5, is described in Attachment A of CR7505, which is viewable at <http://www.cms.gov/Transmittals/downloads/R77DEMO.pdf> on the Centers for Medicare & Medicaid services (CMS) website.
9. If a hospital offers swing bed services, the Medicare FI/MAC will calculate two separate target amounts for the purpose of calculating reimbursement:
 - for acute care services; and
 - for swing-bed services.
10. If a hospital provides only acute care services, then there will be only one target amount for acute care services.
11. Hospitals participating in the demonstration will be able to participate in other CMS demonstrations.
12. Hospitals participating in the demonstration will not be able to receive the low volume payment adjustment in addition.
13. The MAC or FI will not make any Medicare disproportionate share payment in addition to the cost-based payment for inpatient services. For each cost reporting period, the MAC or FI will collect necessary data from each hospital for the provider specific file in order

to calculate disproportionate share percentages. The purpose of this data collection is that hospitals will use these percentages to potentially be eligible for non-Medicare benefit programs tied to the disproportionate share percentage or status.

14. Under the demonstration, a hospital will also not receive add-on payments as a Sole Community Hospital or Medicare Dependent Hospital.
15. If in either Fiscal Year (FY) 2011 or FY 2012 a participating hospital receives an additional payment for qualifying hospitals with lowest enrollee Medicare spending under section 1109 of the Affordable Care Act, the MAC or FI will subtract the amount paid under this provision from the cost-based payment for Medicare inpatient services calculated under this demonstration methodology. This deduction will be made only if the additional payment being made to the hospital under Section 1109 occurs at a point in time concurrent with the hospital's period of performance in the demonstration. For example: if payment under Section 1109 occurs in September 2011, and:
 - A hospital is one of the originally participating hospitals, beginning the extension period with cost report period starting January 1, 2010, then the amount received under Section 1109 will be subtracted from the demonstration payment for the cost report year January 1, 2011 –December 31, 2011.
 - A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year July 1, 2011 – June 30, 2012, then the amount received under Section 1109 will be subtracted from the demonstration payment for that cost report year.
 - A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year January 1, 2012 – December 31, 2012, then the amount of the payment for FY 2011 will not be subtracted for the hospital.
16. Since hospitals participating in the demonstration are considered to be subsection (d) hospitals, they will be able to participate in the Medicare Health Information Technology (HIT) incentive payment program. They will be required to follow the regulations as subsection (d) hospitals.

The following hospitals are participating in the demonstration and they will also be receiving additional payments under Section 1109:

Originally Participating Hospitals –

- Columbus Community Hospital, Columbus, NE;
- Holy Cross Hospital, Taos, NM;
- Brookings Hospital, Brookings, SD; and
- Garfield Memorial Hospital, Panguitch, UT.

Newly Selected Hospitals –

- Yampa Valley Medical Center, Steamboat Springs, CO;
- St Anthony Regional Hospital, Carroll, IA;
- Skiff Medical Center, Newton, IA;
- Lakes Regional Healthcare, Spirit Lake, IA;
- Grinnell Regional Medical Center, Grinnell, IA;
- Geary Community Hospital, Junction City, KS;
- Miles Memorial Hospital, Damariscotta, ME;
- Inland Hospital, Waterville, ME;
- San Miguel Hospital Corporation, Las Vegas, NM; and
- Cibola General Hospital, Grants, NM.

Additional Information

The official instruction, CR7505 issued to your FI or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R77DEMO.pdf> on the CMS website.

If you have any questions, please contact your 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.

**OCTOBER 2011 QUARTERLY AVERAGE SALES PRICE (ASP)
MEDICARE PART B DRUG PRICING FILES AND REVISIONS TO
PRIOR QUARTERLY PRICING FILES
~CMS MLN Matters~**

MLN Matters® Number: MM7488
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R2264CP

Related Change Request (CR) #: 7488
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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) 7488, which instructs Medicare contractors to download and implement the October 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised July 2011, April 2011, January 2011, and October 2010 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 1, 2011, with dates of service October 1, 2011, through December 31, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

Files	Effective for Dates of Service
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011

Files	Effective for Dates of Service
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010

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 (CR 7488) issued to your Medicare MAC, carrier, and FI may be found at <http://www.cms.gov/Transmittals/downloads/R2264CP.pdf> on the CMS website.

PASS-THROUGH PAYMENT FOR CERTIFIED REGISTERED NURSE ANESTHETIST SERVICES ~CMS MLN Matters~

MLN Matters® Number: MM7379
Related CR Release Date: May 20, 2011
Related CR Transmittal #: R2222CP

Related Change Request (CR) #: 7379
Effective Date: December 2, 2010
Implementation Date: October 3, 2011

Provider Types Affected

This article is for Critical Access Hospitals (CAHs), rural hospitals, and hospitals reclassified as rural submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for Certified Registered Nurse Anesthetist services (CRNA) services provided to Medicare beneficiaries.

What You Need to Know

In the FY 2011 Inpatient Prospective Payment System (IPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) amended the location requirements for CAHs and rural hospitals to be eligible for CRNA pass-through payments by changing the regulations to state that effective with cost reporting periods beginning on or after October 1, 2011, in addition to CAHs and hospitals geographically located in a rural area, if a hospital has reclassified as rural, either under the IPPS or to become a CAH, under the regulations at 42 Code of Federal Regulations (CFR) 412.103, it is also eligible to receive CRNA pass-through payments.

In the CY 2011 Outpatient PPS rule, the effective date of the CRNA policy change regarding location requirements was changed to December 2, 2010. CR7379 alerts Medicare Contractors that effective December 2, 2010, in addition to hospitals and CAHs geographically located in rural areas, hospitals that have reclassified as rural, either under the IPPS or to become CAHs, under the regulations at 42 CFR 412.103 are also eligible to be paid based on reasonable cost.

Background

Certain hospitals and critical access hospitals (CAHs) are eligible to be paid based on reasonable cost for CRNA services if they meet the requirements outlined at 42 CFR 412.113(c). Prior to a change in policy regarding location requirements made in the fiscal year (FY) 2011 Inpatient Prospective Payment System (IPPS) final rule, hospitals and CAHs were

required to be geographically located in rural areas in order to be eligible for CRNA pass-through payments.

Note: Medicare contractors will not search and adjust claims processed prior to implementation of this change. However, they will adjust such claims that you bring to their attention.

Additional Information

The official instruction, CR 7379 issued to your FI and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2222CP.pdf> on the CMS website.

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

PAYMENT UPDATE AND COMMON WORKING FILE (CWF) EDITING FOR INFLUENZA VIRUS VACCINE AND PNEUMOCOCCAL VACCINE (PPV) CODES

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM7128 Revised
Related CR Release Date: May 5, 2011
Related CR Transmittal #: R2212CP

Related Change Request (CR) #: 7128
Effective Date: October 1, 2010
Implementation Date: July 5, 2011

Note: This article was revised on July 1, 2011, to reflect the revised CR7128 issued on May 5, 2011. The article was revised to reflect the new CR transmittal number and release date. Also, the web address for accessing CR7128 was revised. All other information is the same.

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers and A/B Medicare Administrative Contractors (MACs) for Medicare beneficiaries receiving influenza vaccines or PPVs are affected.

What You Need to Know

The influenza virus vaccine Healthcare Common Procedure Coding System (HCPCS) code 90662 (Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use) and PPV HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) are being added to existing edits to prevent payment duplication for claims processed on or after July 5, 2011. Make sure your coding and billing staff is aware of this change.

Background

In order to prevent duplicate payments for influenza virus vaccine and PPV claims by the same contractor, CMS has implemented a number of edits that were effective for claims received on or after July 1, 2002.

Change Request (CR) 7128 provides instructions for payment and Common Working File edits to be updated to include influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 for claims processed on or after July 5, 2011.

Basis for Influenza Vaccine and PPV Payments

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to hospitals (Types of Bill (TOB) 12X and 13X), skilled nursing facilities (SNFs) (TOBs 22X and 23X), home health agencies (HHAs) (TOB 34X), hospital-based renal dialysis facilities (RDFs) (TOB 72X), and critical access hospitals (CAHs) (TOB 85X) is based on reasonable cost;
- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to Indian Health Service (IHS) hospitals (TOB 12X, 13X) and IHS CAHs (TOB 85X) is based on 95% of the Average Wholesale Price (AWP); and
- The payment for influenza virus vaccine HCPCS code 90662 and PPV code 90670 to Comprehensive Outpatient Rehabilitation Facilities (TOB 75X) and independent RDFs (TOB 72X) is based on the lower of the actual charge or 95% of the Average Wholesale Price.

Contractors will not search their files to either retract payment for claims already paid or retroactively pay claims. However, they will adjust claims brought to their attention.

Additional Information

The official instruction, CR 7128 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2212CP.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.

PHASE 3 OF MANUAL REVISIONS TO REFLECT PAYMENT CHANGES FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS) ITEMS AS A RESULT OF THE DMEPOS COMPETITIVE BIDDING PROGRAM AND THE DEFICIT REDUCTION ACT OF 2005

~CMS MLN Matters~

MLN Matters® Number: MM7401
Related CR Release Date: May 27, 2011
Related CR Transmittal #: R2231CP

Related Change Request (CR) #: 7401
Effective Date: August 28, 2011
Implementation Date: August 28, 2011

Provider Types Affected

This article is for Medicare DMEPOS suppliers that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for DMEPOS that they refer or order for Medicare beneficiaries.

What You Need to Know

Change Request (CR) 7401, from which this article is developed, is the third installment of, and adds information to, Chapter 36 DMEPOS Competitive Bidding Program in the “Medicare Claims Processing Manual” and provides additional information for Medicare contractors and suppliers on the Round One Rebid Implementation. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The phase one MLN Matters® article CR5978 is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM5978.pdf> on the Centers for Medicare & Medicaid services (CMS) website. CR 6119 provided the second installment of Chapter 36 and details the second phase of the manual revisions to this program. The related MLN Matters® article CR6119 is available at <http://www.cms.gov/MLNMattersArticles/Downloads/MM6119.pdf> on the CMS website.

Background

The Medicare payment for most DMEPOS was traditionally based on fee schedules. When section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) was amended, a competitive bidding program was implemented to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

CMS issued the regulation for the competitive bidding program on April 10, 2007 (72 Federal Register 17992). Round One of the National Competitive Bidding (NCB) Program was implemented on January 1, 2011. CR 7401 provides additional instructions on changes under the DMEPOS Competitive Bidding Program. This regulation is available at <http://www.cms.gov/DMEPOSCompetitiveBid/> on the CMS website.

Key Points of CR7401

There are seven additions to section 50 of Chapter 36 of the “Medicare Claims Processing Manual”; one is an update and the other six are new additions:

- Section 50.3 is updated to include new HCPCS modifiers developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories.
 - For example, HCPCS code E0981 (Wheelchair Accessory, Seat Upholstery, Replacement Only, Each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category must submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category must use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers.
 - The KG and KK modifiers are used in Round I of the competitive bidding program and the KU and KW modifiers are reserved for future program use.

The six sections added to Chapter 36: 50.10 through 50.15 as follows:

- 50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items;
 - Under DMEPOS Competitive Bidding, hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a

- bid and being awarded a contract. The DME items that a hospital may furnish as part of the exception are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. Payment for items furnished under this exception will be made based on the single payment amount for the item for the Competitive Bidding Area (CBA) where the beneficiary resides. Separate payment is not made for walkers and related accessories furnished by a hospital on the date of admission because payment for these items are included in the Part A payment for inpatient facility services. Refer to the “Medicare Claims Processing Manual,” Chapter 1, 10.1.1.1 for instructions for submitting claims at <http://www.cms.gov/manuals/downloads/clm104c01.pdf> on the CMS website.
- 50.11 - Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan;
 - Under DMEPOS Competitive Bidding, if a beneficiary resides in a CBA and elects to leave their MA plan or loses his/her coverage under this plan, the beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program. However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier, meet the Medicare Fee-For-Service coverage criteria and documentation requirements, and must elect to become a grandfathered supplier. All competitive bid grandfathering rules apply in these situations.
 - 50.12 – Claims for Repairs and Replacements;
 - Under the DMEPOS Competitive Bidding Program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier will be based on the single payment amount for the part, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.
 - **The replacement of an entire item, as opposed to the replacement of a part for repair purposes, which is subject to the DMEPOS Competitive Bidding Program, must be furnished by a contract supplier.** Medicare payment for the replacement item would be based on the single payment amount for the item in the beneficiary’s CBA. Refer to the “Medicare Claims Processing Manual,” Chapter 20, 10-2 at <http://www.cms.gov/manuals/downloads/clm104c20.pdf> for instruction for submitting claims for repairs and replacements.
 - 50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap;
 - The Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment. This requirement continues to apply under the Medicare DMEPOS Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered

- supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a CBA).
- Should a beneficiary travel or temporarily relocate to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.
 - The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.
- 50.14 - Purchased Accessories & Supplies for Use With Grandfathered Equipment; and
 - Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011 for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:
 - Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562;
 - Hospital Beds and Related Accessories – E0271, E0272, E0280, E0310; and
 - Walkers and Related Accessories – E0154, E0156, E0157, and E0158.
 - Grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.
 - After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.
 - 50.15 - Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge.
 - Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.
 - To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.

- Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.
- The J4 modifier should not be used by contract suppliers.

Additional Information

If you have any questions, please contact your Medicare 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. The official instruction associated with this CR7401, issued to your Medicare MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2231CP.pdf> on the CMS website. Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at <https://www.cms.gov/DMEPOSCompetitiveBid/> on the CMS website. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

QUARTERLY HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) DRUG/BIOLOGICAL CODE CHANGES – JULY 2011 UPDATE
~CMS MLN Matters~

MLN Matters® Number: MM7303
 Related CR Release Date: May 24, 2011
 Related CR Transmittal #: R2227CP

Related Change Request (CR) #: 7303
 Effective Date: July 1, 2011
 Implementation Date: July 5, 2011

Provider Types Affected

This article is for physicians, other 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 Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR7303 announces the quarterly updating of specific Health Care Procedure Code System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2011. You should make sure that your billing staffs are aware of these HCPCS code changes.

Non-payable Code

Effective for claims with dates of service on or after July 1, 2011, Medicare will not pay for the following HCPCS code:

HCPCS Code	Short Description	Long Description	Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator
J7184	Wilate injection	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 100 I.U. VWF-RCO	I

Payable Codes

Contractors will accept the codes in the following table as payable HCPCS codes for dates of service on or after July 1, 2011, using Type of Service (TOS) 1, 9, and Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator "E" (Excluded from Physician Fee Schedule by Regulation):

HCPCS Code	Short Description	Long Description
Q2041	Wilate Injection	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF-RCO
Q2042	Hydroxyprogesterone caproate	INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG
Q2043	Sipuleucel-T auto CD54+	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION
Q2044	Belimumab injection	INJECTION, BELIMUMAB, 10 MG

Additional Information

You can find the official instruction, CR7303, issued to your Medicare contractor by visiting <http://www.cms.gov/Transmittals/downloads/R2227CP.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.

**QUARTERLY UPDATE TO THE END-STAGE RENAL DISEASE
PROSPECTIVE PAYMENT SYSTEM
~CMS MLN Matters~**

MLN Matters® Number: MM7476
Related CR Release Date: July 15, 2011

Related Change Request (CR) #: 7476
Effective date s: 10/1/2011-ICD-9 Updates;
1/1/2011-DME Updates

Related CR Transmittal #: R2255CP

Implementation Date: October 3, 2011

Provider Types Affected

Physicians, providers, and suppliers, including End-Stage Renal Disease (ESRD) facilities and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, submitting claims to Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs), or A/B MACs for ESRD supplies and services provided to Medicare beneficiaries are affected by this article.

Provider Action Needed

This article, based on Change Request (CR) 7476, advises you about the following corrections to Attachment 4 and Attachment 5 provided in CR7064:

- Removes equipment and supply codes from Attachment 4 that are not separately payable to DMEPOS suppliers, and
- Adds these removed codes to Attachment 5.

You are also advised of the update to Attachment 8 provided with CR7064, which is the list of ICD-9-CM codes eligible for the ESRD Prospective Payment System (PPS) co-morbidity payment adjustment. The list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective January 1, 2011 and the list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011, are available at http://www.cms.gov/ESRDPayment/40_Comorbid_Conditions.asp#TopOfPage on the Centers for Medicare & Medicaid Services (CMS) website.

The revised attachments 4 and 5 are attached to CR7476 at <http://www.cms.gov/Transmittals/downloads/R2255CP.pdf> on the CMS website. Items and services that are subject to the ESRD PPS consolidated billing requirements can be found at http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage on the CMS website.

Please be sure to inform your staffs of these changes.

Background

MM7064, entitled “End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services,” advised you about the implementation of a new bundled payment system for renal dialysis items and services provided on and after January 1, 2011. You may review this article by going to <http://www.cms.gov/MLNMArticles/downloads/MM7064.pdf> on the CMS website.

The ESRD PPS provides payment adjustments for six categories (three acute and three chronic) of co-morbid conditions. When applicable, ESRD facilities can report specific ICD-9-CM diagnosis codes on ESRD facility claims to be eligible for a co-morbidity payment adjustment. The ICD-9-CM codes are updated annually and are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and are effective each October 1. CR7476 provides updates to attachment 8 of CR7064, which includes the ICD-9-CM codes eligible for the ESRD PPS co-morbidity payment adjustment in accordance with the annual ICD-9-CM update, which is effective October 1, 2011.

Changes to the ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 include:

1. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.41 – Sickle-cell thalassemia without crisis has been revised to include microdrepanocytosis.
2. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, the 5 new ICD-9 codes added are as follows:

- 282.43 Alpha thalassemia

- Alpha thalassemia major
- Hemoglobin H Constant Spring
- Hemoglobin H disease

- Hydrops fetalis due to alpha thalassemia
 - Severe alpha thalassemia
 - Triple gene defect alpha thalassemia
- Excludes:** alpha thalassemia trait or minor (282.46); hydrops fetalis due to isoimmunization (773.3); hydrops fetalis not due to immune hemolysis (778.0)

- 282.44 Beta thalassemia

- Beta thalassemia major
 - Cooley's anemia
 - Homozygous beta thalassemia
 - Severe beta thalassemia
 - Thalassemia intermedia
 - Thalassemia major
- Excludes:** beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); hemoglobin E beta thalassemia (282.47); sickle-cell beta thalassemia (282.41, 282.42)

- 282.45 Delta-beta thalassemia

- Homozygous delta-beta thalassemia
- Excludes: delta-beta thalassemia trait (282.46)

- 282.46 Thalassemia minor

- Alpha thalassemia minor
 - Alpha thalassemia trait
 - Alpha thalassemia silent carrier
 - Beta thalassemia minor
 - Beta thalassemia trait
 - Delta-beta thalassemia trait
 - Thalassemia trait NOS
- Excludes:** alpha thalassemia (282.43); beta thalassemia (282.44); delta beta thalassemia (282.45); hemoglobin E-beta thalassemia (282.47); sickle-cell trait (282.5)

- 282.47 Hemoglobin E-beta thalassemia

- Excludes:** beta thalassemia (282.44); beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); delta-beta thalassemia trait (282.46); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle-cell beta thalassemia (282.41, 282.42)

3. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to no longer include Cooley's anemia, Hb-Bart's disease, Microdrepanocytosis, Thalassemia (alpha) (beta) (intermedia) (major) (minima) (minor) (mixed) (trait), and Thalassemia NOS.
4. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to include Dominant thalassemia, Hemoglobin C thalassemia, Mixed thalassemia, and continues to include Thalassemia with other hemoglobinopathy.
5. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to exclude

hemoglobin C disease (282.7); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle cell anemias (282.60-282.69); and sickle-cell beta thalassemia (282.41-282.42)

Attachment 4 of CR7064, DME ESRD Supply Healthcare Common Procedure Coding System (HCPCS) for ESRD PPS Consolidated Billing Edits, included the list of equipment and supplies that are ESRD-related but can be used in other provider settings for reasons other than for the treatment of ESRD. Attachment 5 of CR7064, DME ESRD Supply HCPCS Not Payable to DME Suppliers, included the list of the DME ESRD supply codes that are no longer separately payable to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers. To allow DMEPOS suppliers to get paid for furnishing these services under other circumstances covered by Medicare, CR7064 provided instructions stating that DMEPOS suppliers may bill the items listed on Attachment 4 with the AY modifier to indicate that the item is used for reasons other than for the treatment of ESRD. Currently, there are equipment and supplies listed on Attachment 4 that are not used in other provider settings and would therefore never be used for reasons other than for the treatment of ESRD. Therefore, these items would not be covered by Medicare because there is no other benefit category that can provide coverage. CR7476 rescinds and replaces Attachments 4 and 5 of CR7064 as follows: Removes equipment and supply codes from Attachment 4 that are either not separately payable or not payable by Medicare and add these codes to Attachment 5. Surgical dressing code A6204 will also be included in Attachment 5.

Additional Information

The official instruction, CR7476, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2255CP.pdf> on the CMS website. If you have any questions, please contact your FI, 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.

REPORTING OF RECOUPMENT FOR OVERPAYMENT ON THE REMITTANCE ADVICE (RA)

~ Revised CMS MLN Matters ~

MLN Matters® Number: MM6870 Revised
Related CR Release Date: June 9, 2011
Related CR Transmittal #: R906OTN

Related Change Request (CR) #: 6870
Effective Date: July 1, 2010
Implementation Date: July 6, 2010, except
July 5, 2011, for claims processed by the
FISS system used by FIs and A/B MACs

Note: This article was revised on June 10, 2011, to reflect a revised CR6870 issued on June 9. The CR release date, transmittal number, implementation date for FISS, and the web address for accessing CR6870 have been revised. All other information is the same.

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative

Contractors (A/B MACs)) for services provided to Medicare beneficiaries. (CR6870 does not apply to suppliers billing Durable Medical Equipment (DME) MACs.)

Provider Action Needed

This article is based on Change Request (CR) 6870 which instructs Medicare System Maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC Program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You can review Section 1893 http://www.ssa.gov/OP_Home/ssact/title18/1893.htm on the Internet. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the Medicare Learning Network® (MLN) Matters® article related to CR6183 at <http://www.cms.gov/MLNMArticles/downloads/MM6183.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.)

Under the scenario just described, the Remittance Advice (RA) has to report the actual recoupment in two steps:

- **Step I:** Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here);
- **Step II:** Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the RA to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR6870 instructs the Medicare System Maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an Internal Control Number (ICN) or Document Control Number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:**Claim Level:**

The original payment is taken back and the new payment is established

Provider Level:

PLB03-1 – PLB reason code FB (Forward Balance)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II:**Claim Level:**

No additional information at this step

Provider Level:

PLB03-1 – PLB reason code WO (Overpayment Recovery)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional Information

CMS provides more information including an overview of and recent updates for the RAC program at <http://www.cms.gov/RAC/> on the CMS website. You can find the guide “Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers” at http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

The official instruction, CR6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R906OTN.pdf> on the CMS website.

You may also want to review MLN Matters® article MM7068, which is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7068.pdf> on the CMS website. It instructs DME MACs to provide enough detail in the RA to enable DMEPOS suppliers to reconcile their claims.

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 2012 ~CMS MLN Matters~

MLN Matters® Number: MM7367

Related CR Release Date: May 20, 2011

Related CR Transmittal #: R2220CP

Related Change Request (CR) #: 7367

Effective Date: Discharges on or after July 1, 2011

Implementation Date: July 5, 2011

Provider Types Affected

Providers submitting claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) are affected.

Provider Action Needed

This article is based on Change Request (CR) 7367 which identifies changes that are required as part of the annual IPF PPS update from the Rate Year (RY) 2012 IPF PPS update notice, published on April 29, 2011. These changes are applicable to IPF discharges occurring during the rate year July 1, 2011, through September 30, 2012, and this is the sixth RY update to the IPF PPS. The applicable previous year update is detailed in MLN Matters® article MM6986 and may be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM6986.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. Make sure that your billing staff is 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.

Note that, effective with RY 2012, the IPF PPS payment rate update period will switch from a (RY) that begins on July 1 ending on June 30 to a period that coincides with a fiscal year (FY.) To transition from a RY to a FY basis, the IPF PPS RY 2012 will cover the 15 month period from July 1, 2011, – September 30, 2012. This change to the payment update period will allow one consolidated annual update to both the rates and the ICD-9-CM coding changes (MS-DRG and co-morbidities). Coding and rate changes will continue to be effective October 1 of each year thereafter.

Change Request (CR) 7367 identifies changes that are required as part of the annual IPF PPS update from the RY 2012 IPF PPS update notice, published on April 29, 2011.

Key Points of CR7367

Market Basket Update

For RY 2012, CMS rebased and revised the FY 2002-based RPL (Rehabilitation, Psychiatric and Long Term Care) market basket to a FY 2008-based RPL market basket.

Section 1886(s)(3)(A) of the Social Security Act, which was added by Section 3401(f) of the Affordable Care Act, requires the application of an “Other Adjustment” that reduces any update to the IPF PPS base rate by 0.25 percentage point for the rate year beginning in 2012. Applying the market basket increase of 3.2 percent, with the “Other Adjustment” of -0.25 percentage point, and the wage index budget neutrality factor of 0.9995 to the RY 2011 Federal per diem base rate of \$665.71 yields a Federal per diem base rate of \$685.01 for RY 2012. Similarly, applying the market basket increase with the “Other Adjustment,” and the wage index budget neutrality factor to the RY 2011 electroconvulsive therapy (ECT) rate yields an ECT rate of \$294.91 for RY 2012.

PRICER Updates

- The Federal per diem base rate is \$685.01.
- The fixed dollar loss threshold amount is \$7,340.00.
- The IPF PPS will use the FY 2011 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 70.317 percent.
- The non-labor related share is 29.683 percent.
- The ECT rate is \$294.91.

The National Urban and Rural Cost to Charge Ratios for the IPF Prospective Payment System Rate Year 2012:

Cost to Charge Ratio	Median	Ceiling
Urban	0.5055	1.7643
Rural	0.6435	1.8199

CMS is applying the national median Cost-to-Charge Ratios (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 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 the IPF PPS RY 2012.

FY 2010 Pre-floor, Pre-reclassified Hospital Wage Index

CMS is using the updated wage index and the wage index budget neutrality factor of 0.9995.

COLA Adjustment

The Office of Personal Management (OPM) began transitioning from cost of living adjustment (COLA) factors to a locality payment rate in FY 2010. The 2009 COLA factors were frozen in order to allow this transition. In order to provide a full COLA for Alaska and Hawaii, CMS is adopting the FY 2009 COLA rates obtained from the OPM website. The COLA rates for the areas of Alaska and Hawaii are reflected in the following two tables:

Alaska	Cost of Living Adjustment Factor
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25

Hawaii	Cost of Living Adjustment Factor
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Additional Information

The official instruction, CR 7367, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2220CP.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 FY 2012**
~CMS MLN Matters~

MLN Matters® Number: MM7518
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R2260CP

Related Change Request (CR) #: 7518
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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) 7518 which provides the annual update to the hospice payment rates for Fiscal Year (FY) 2012, the hospice aggregate cap amount for the cap period ending October 31, 2011, and the hospice wage index and Pricer for FY 2012. Be sure your billing staffs are aware of these changes, which are described in the Background and Key Points sections, 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)).

Key Points

FY 2012 Hospice Payment Rates

The FY 2012 payment rates will be the FY 2011 payment rates, increased by 3.0 percentage points, which is the total hospital market basket percentage increase forecasted for FY 2012. The FY 2012 hospice payment rates are shown in the following table and are effective for care and services furnished on or after October 1, 2011, through September 30, 2012.

Code	Description	Rate	Wage Component Subject to Index	Non- Weighted Amount
651	Routine Home Care	\$151.03	\$103.77	\$ 47.26
652	Continuous Home Care Full Rate = 24 hours of care \$36.73= hourly rate	\$881.46	\$605.65	\$275.81
655	Inpatient Respite Care	\$156.22	\$ 84.56	\$ 71.66
656	General Inpatient Care	\$671.84	\$430.04	\$241.80

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.gov/manuals/downloads/clm104c11.pdf> on the CMS website.

Hospice Cap

The latest hospice cap amount for the cap year ending October 31, 2011, is **\$24,527.69**. In computing the cap, CMS used the medical care expenditure category of the March 2011 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 397.726. 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.gov/manuals/downloads/clm104c11.pdf> on the CMS website).

Hospice Wage Index

The FY 2012 Hospice Wage Index final rule will be effective October 1, 2011, 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.

Be Aware: Hospice providers should split claims if dates of service span separate fiscal years, e.g., September/October billing as the FY 2011 rates will be used if the hospice chooses not to split the claim and your Medicare Contractor will perform no subsequent adjustments to these claims.

Additional Information

The official instruction, CR7518 issued to your carrier, A/B MAC, and FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2260CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, A/B 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.

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