

# Communiqué

# Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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**Items of Importance****IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

WPS Medicare will close for the following holidays:

<u>Date</u>	<u>Holiday</u>
September 1, 2008	Labor Day

**NEW 2008 MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES EFFECTIVE FOR DATES OF SERVICE JULY 1, 2008 THROUGH DECEMBER 31, 2008**

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate of -10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, non-physician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 % update rates in approximately 10 business days, or less. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, non-physician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims that have been on hold on a rolling basis (first in/first out) for payment at the -10.6% update level. After your local contractor begins to pay claims at the new 0.5% rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Contractor Websites are being updated with the new rates and these should be available shortly.

Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

Finally, be on the alert for more information about other legislative provisions which may affect you.

Further instructions regarding other provisions of MIPPA will be forthcoming.

## PROMPT PAYMENT ACT INTEREST RATE

Although the Renegotiation Board is no longer in existence, other federal agencies are required to use interest rates computed under the criteria established by the Renegotiation Act of 1971 (P.L. 92-41). For example, the Contract Dispute Act of 1978 (P.L. 95-563) and the Prompt Payment Act (P.L. 97-177) provide for interest due on claims at a rate established by the Secretary of the Treasury pursuant to 31 U.S.C. § 3902(a).

For the period beginning July 1, 2008 and ending December 31, 2008, the rate of interest applicable for the purpose of the cited sections is 5.125% (5.125 per centum) per annum. The rate of interest was published in the Federal Register Volume 73, Number 127, page 37529 on Tuesday, July 1, 2008.

**Claim Submission****CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE  
UPDATE****~CMS MLN Matters~****MLN Matters Number: MM6090****Related Change Request (CR) #: 6090****Related CR Release Date: June 13, 2008****Effective Date: October 1, 2008****Related CR Transmittal #: R1533CP****Implementation Date: October 6, 2008****Provider Types Affected**

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

**What You Need to Know**

CR 6090, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

**Background**

The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1).

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6090, from which this article is taken, updates the changes in the Claim Status Codes and Claim Status Category Codes from the February 2008 committee meeting, which were posted at <http://www.wpc-edi.com/content/view/180/223/> on February 29, 2008 (previously referenced by <http://www.wpc-edi.com/codes>). CR6090 reminds Medicare contractors that they must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by its implementation date (October 6, 2008). On and after this date, these code changes are to be used in editing of all X12 276 transactions processed, and to be reflected in the X12 277 transactions issued.

**Additional Information**

You can find the official instruction, CR6090, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1533CP.pdf> on the CMS Website

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

## CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY FOR OBSTRUCTIVE SLEEP APNEA (OSA)

~CMS MLN Matters~

MLN Matters Number: MM6048

Related CR Release Date: July 3, 2008

Related CR Transmittal #: R86NCD

Related Change Request (CR) #: 6048

Effective Date: March 13, 2008

Implementation Date: August 4, 2008

### Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment (DME) MACs) for OSA-related services provided to Medicare beneficiaries.

### Impact on Providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

### Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the Medicare NCD Manual (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. (Note that billing guidelines for capped rental equipment are contained in the Medicare Claims Processing Manual, Chapter 20, Section 30.5, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf> on the CMS Website.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

### Key Points of CR6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

**NOTE:** DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively. 42 CFR 424.57(c)(12). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges. 42 CFR 424.57(d).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
  - Polysomnography (PSG) performed in a sleep laboratory; or
  - Unattended home sleep monitoring device of Type II; or
  - Unattended home sleep monitoring device of Type III; or
  - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

**NOTE:** In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Distress Index (RDI) is met:
  - AHI or RDI greater than or equal to 15 events per hour, or
  - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

**Note:** The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the

Medicare Claims Processing Manual. These manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

**Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.**

**G0398:** Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.

**G0398** Short Descriptor: Home sleep test/type 2 Porta

**G0399:** Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

**G0399** Short Descriptor: Home sleep test/type 3 Porta

**G0400:** Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

**G0400** Short Descriptor: Home sleep test/type 4 Porta

#### Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R86NCD.pdf> on the CMS Website.

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

## JULY 2008 INTEGRATED OUTPATIENT CODE EDITOR (I/OCE) SPECIFICATIONS VERSION 9.2

~CMS MLN Matters~

MLN Matters Number: MM6080 **Revised**

Related Change Request (CR) #: 6080

Related CR Release Date: July 18, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1560CP

Implementation Date: July 7, 2008

**Note: This article was revised on July 21, 2008, to reflect changes made to CR6080 on July 18, 2008. CR6080 was revised to reflect a legislative change that continues the cost-to-charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This required some adjustments to the table on pages 3-4 of this article. Also, the CR release date, transmittal number, and the Web address for accessing CR6080 were revised. All other information remains the same.**

#### Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for outpatient services provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 6080 which provides the Integrated OCE instructions and specifications for the July, 2008, I/OCE that will be used for processing Outpatient Prospective Payment System (OPPS) and Non-OPPS claims from hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

**Background**

Change Request (CR) 6080 informs providers and the Fiscal Intermediaries (FIs) and A/B MACs that the I/OCE is updated for July 1, 2008. The I/OCE routes all institutional outpatient claims (which includes non-OPPS through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

Claims with dates of service prior to July 1, 2007 are routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

CR 6080 provides the I/OCE instructions and specifications that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE instructions are attached to CR 6080 and will also be posted at <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the Centers for Medicare & Medicaid Services (CMS) Website.

CR 6080 also includes as an attachment with detailed lists of the ambulatory payment classifications (APC), health care common procedure coding systems (HCPCS), and Current Procedural Terminology (CPT) code changes, additions, and deletions. We will not repeat all of those changes in this article. However, the key modifications of the OCE for the July 2008 release (V9.2) are summarized in the table below. In the table note that:

- Highlighted sections indicate change from the prior release of the software; and
- Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

Effective Date	Edit	Summary of Change
7/1/08	24	Modify the software to maintain/retain 28 prior quarters (7 years) of programs & codes in each release. Remove older versions with each release. (The earliest version date included in the July 2008 release will be 4/1/01).
7/1/08	50	Change disposition for edit 50 to RTP ( <b>Return to Provider</b> ). <b>Note: The IOCE change to RTP this claim will no longer trigger an initial determination. The provider should bill statutorily excluded services as noncovered and affix liability with the GY modifier (beneficiary liable).</b>

Effective Date	Edit	Summary of Change
4/1/01		Exclude denied or rejected lines from PHP (Partial Hospitalization Program) processing and from Daily Mental Health assignment criteria
		Make HCPCS/APC/SI changes as specified by CMS
	19, 20, 39, 40	Implement version <b>14.1</b> of the NCCI (National Correct Coding Initiative) file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
1/1/08	17	Remove codes 92621 and 92627 from the Inherently bilateral list – change bilateral indicator to '0'
7/1/08	15	Change all max units to zero for all codes that currently have max unit values other than zero.
1/1/08	78	Update nuclear medicine/radiopharmaceutical edit requirements
7/1/08	71/77	<b>Update procedure/device edit requirements</b>
7/1/08	22	<b>Add new modified CG (“Policy criteria applied”) to the valid modifier list.</b>
		Documented some 'general programming notes' that were in effect but not previously documented
		Documented the exclusion of denied or reject lines from composite criteria
1/1/08	68	Implement mid-quarter NCD activation date for specified G codes and apply to G0398, G0399, and G0400 if Date of Service is before 3/13/08.
		Create a 508 Compliant version of the document (modify as necessary) – for publication on CMS Website

#### Additional Information

The official instruction, CR 6080, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1560CP.pdf> on the CMS Website.

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

**MEDICARE ACUTE CARE EPISODE (ACE) DEMONSTRATION. CR 6001 RESCINDS AND FULLY REPLACES CR 5767****~CMS MLN Matters~****MLN Matters Number: MM6001****Related Change Request (CR) #: 6001****Related CR Release Date: June 27, 2008****Effective Date: Admissions occurring on or after  
January 1, 2009****Related CR Transmittal #: R58DEMO****Implementation Date: January 1, 2009****Provider Types Affected**

Hospitals submitting claims to Medicare contractors (especially those providers billing the Part A/B Medicare Administrative Contractor (A/B MAC)) in Medicare MAC jurisdiction 4. Physicians and other providers treating inpatients or referring inpatients covered by the demonstration within MAC jurisdiction 4 may also find this article of interest.

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

This article is based on Change Request (CR) 6001 which provides details regarding the Medicare Acute Care Episode (ACE) Demonstration and rescinds and replaces CR 5767 (Transmittal 55, dated January 25, 2008). The article is informational, especially for hospitals and providers in Texas, Oklahoma, Colorado, and New Mexico. Only hospitals in those states may apply to participate in this demonstration.

**CAUTION – What You Need to Know**

CR 6001 remains the same as CR 5767 (Transmittal 55) except for specifying that the geographic location of the Medicare Acute Care Episode (ACE) Demonstration is A/B MAC Jurisdiction 4 (Texas, Oklahoma, Colorado, and New Mexico). Only providers in these states may volunteer to participate in the ACE demonstration. CR 6001 also contains claims processing instructions and changes required for Medicare systems to process and pay for acute inpatient episodes of care under this demonstration. A summary of the demonstration design and how it relates to the required system changes is included in Attachments I through V of CR 6001.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding this demonstration project.

**Background**

The Acute Care Episode (ACE) Demonstration is being implemented under the provisions of the Medicare Health Care Quality Demonstration Programs (Social Security Act; Section 1866C; see [http://www.ssa.gov/OP\\_Home/ssact/title18/1866C.htm](http://www.ssa.gov/OP_Home/ssact/title18/1866C.htm) on the Internet), as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173; Section 646). Section 1866C of the Social Security Act allows the Secretary to approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources.

As a value-based purchaser of care, the Centers for Medicare & Medicaid Services (CMS) seeks to devise and test new methods of paying providers that will encourage improvements in both the efficiency and quality of care provided to Medicare beneficiaries. With this in mind, the goal of the ACE Demonstration is to align hospitals' and physicians' incentives to work together to provide coordinated, cost-effective care by:

- Bundling all related services into an "episode of care," and
- Paying a single, global payment that can be used as the providers of care deem most appropriate.

It is expected that the ACE Demonstration will achieve savings to the Medicare program and give hospitals and physicians the flexibility to allocate resources as they determine to be most appropriate.

Approximately 15 demonstration sites will be selected to participate in this demonstration, currently projected to start on January 1, 2009, with site selection occurring during the fall of 2008. Sites will be selected from states previously mentioned in this article that pay claims under the diagnostic related group (DRG) inpatient prospective payment system (IPPS). Individual demonstration sites will participate for three years from their first date of operation, and CMS has the option to add demonstration sites.

All proposals will be thoroughly reviewed by a technical expert panel to insure the organization's capacity to carry out the demonstration. Entities may submit proposals for a global payment under the demonstration for one or more of the categories listed in Attachment II of CR 6001. However, if a demonstration site is selected for a particular category of DRGs, all admissions for eligible beneficiaries to the facility for DRGs in that category shall be processed under the demonstration payment rules. In addition, participating entities will be required to submit quality data relevant to the services being provided under the demonstration.

CMS staff will provide Medicare contractors with a list of all demonstration providers and their associated identification numbers (e.g. National Provider Identifier (NPI), Medicare legacy provider identification number, etc) as well as DRGs covered under the demonstration for each facility. This information is expected to be relatively static and stable during the course of the demonstration. However, there is the possibility that some information may require infrequent updates during the course of the demonstration.

Systems will be operational to process claims under this demonstration with dates of admission on or after January 1, 2009. Claims will begin to be processed under the demonstration on January 1, 2009. The period October through December, 2008 will be used to educate providers, beneficiaries, and other stakeholders about the demonstration and test the claims processing systems. Under this demonstration, it is intended that the cost reports and settlement for disproportionate share and indirect medical education be processed based on what the A/B MAC would have paid for Part A services in the absence of the demonstration.

Patients eligible for the demonstration must be eligible for Medicare Part A **and** Part B under Medicare's traditional fee-for-service program and they must have at least one lifetime reserve day at the time of admission to the demonstration hospital in order for the stay to be covered under the demonstration. Beneficiaries enrolled in any type of Medicare health plan

are not eligible for the demonstration, even if all or a portion of the claim is processed using Medicare fee-for-service claims processing systems.

**Additional Information**

The official instruction, CR 6001, issued to your A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R58DEMO.pdf> on the CMS Website. Attached to CR6001 you will find a more detailed description of the demonstration design and the DRGs that may be part of a hospital's demonstration application.

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

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

**REMITTANCE ADVICE REMARK CODE (RARC) AND CLAIM  
ADJUSTMENT REASON CODE (CARC) UPDATE**  
~CMS MLN Matters~

**MLN Matters Number: MM5942**

**Related Change Request (CR) #: 5942**

**Related CR Release Date: March 7, 2008**

**Effective Date: April 1, 2008**

**Related CR Transmittal #: R1475CP**

**Implementation Date: April 7, 2008**

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME MACs)) for services

**Provider Action Needed**

CR 5942, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2008. Be sure billing staff are aware of these changes.

**Background**

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at

<http://www.wpc-edi.com/Codes> on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5942.

CMS has also developed a new tool to help you search for a specific category of code and that tool is available at <http://www.cmsremarkcodes.info> on the Internet. Note that this Website does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

#### Additional Information

To see the official instruction (CR5942) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1475CP.pdf> on the CMS Website.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) on the CMS Website.

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

#### Remittance Advice Remark Code Changes

##### New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 Note: (New Code 11/5/07)	YES
N431	Service is not covered with this procedure. Start: 11/5/2007 Note: (New Code 11/5/07)	YES
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 Note: (New Code 11/5/07)	YES

##### Modified Codes

Code	Current Modified Narrative	Last Modification Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	11/5/2007

Code	Current Modified Narrative	Last Modification Date
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	11/5/2007
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies.	11/5/2007
N367	<b>Alert:</b> The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

### Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997   Stop: 5/1/2008   Last Modified: 11/5/2007 Note: (Deactivated eff. 5/1/08) Consider using Reason Code B4.)	Deactivated eff. 5/1/08

Claim Adjustment Reason Codes**New Codes**

Code	Current Narrative	Implementation Date
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

**Modified Codes**

Code	Modified Narrative	Implementation Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005   Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007   Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier - Invalid format Start: 07/09/2007   Stop: 05/23/2008   Last Modified: 09/30/2007	4/1/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007   Last Modified: 09/30/2007	4/1/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008

<b>Code</b>	<b>Modified Narrative</b>	<b>Implementation Date</b>
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
34	Insured has no coverage for newborns. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
95	Plan procedures not followed. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
129	Prior processing information appears incorrect. Start: 02/28/1997   Last Modified: 09/30/2007	4/1/2008
135	Interim bills cannot be processed. Start: 10/31/1998   Last Modified: 09/30/2007	4/1/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998   Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999   Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999   Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999   Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000   Last Modified: 09/30/2007	4/1/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002   Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002   Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002   Last Modified: 09/30/2007	4/1/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002   Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002   Last Modified: 09/30/2007	4/1/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002   Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002   Last Modified: 09/30/2007	4/1/2008
155	Patient refused the service/procedure. Start: 06/30/2003   Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003   Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003   Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003   Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003   Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004   Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004   Last Modified: 09/30/2007	4/1/2008
165	Referral absent or exceeded. Start: 10/31/2004   Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
169	Alternate benefit has been provided. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
175	Prescription is incomplete. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
186	Level of care change adjustment. Start: 06/30/2005   Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005   Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006   Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006   Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006   Last Modified: 09/30/2007	4/1/2008
198	Precertification/authorization exceeded. Start: 10/31/2006   Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006   Last Modified: 09/30/2007	4/1/2008
203	Discontinued or reduced service. Start: 02/28/2007   Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008

Code	Modified Narrative	Implementation Date
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B16	`New Patient' qualifications were not met. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995   Last Modified: 09/30/2007	4/1/2008

**Deactivated Codes**

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995   Stop: 04/01/2008	4/1/2008
126	Deductible -- Major Medical Start: 02/28/1997   Stop: 04/01/2008   Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997   Stop: 04/01/2008   Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002   Stop: 04/01/2008   Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995   Stop: 04/01/2008   Last Modified: 09/30/2007	4/1/2008

**REVISION OF THE REQUIREMENTS FOR DENIAL OF PAYMENT FOR  
NEW ADMISSIONS (DPNA) FOR SKILLED NURSING FACILITY  
(SNF) BILLING  
~CMS MLN Matters~**

MLN Matters Number: MM6116  
Related CR Release Date: July 18, 2008  
Related CR Transmittal #: R1555CP

Related Change Request (CR) #: 6116  
Effective Date: January 1, 2009  
Implementation Date: January 5, 2009

**Provider Types Affected**

SNFs impacted by payment ban situations and submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in SNFs.

**Impact on Providers**

This article is based on Change Request (CR) 6116 and addresses the consequences that occur when the Centers for Medicare & Medicaid Services (CMS) impose sanctions that preclude Medicare payment for new admissions (or DPNA) to a SNF when a facility is not in substantial compliance with Medicare requirements of participation. Be sure billing staff are aware of these instructions, especially the use of occurrence span code 80 on appropriate claims.

**Background**

Under the Social Security Act at sections 1819(h) and 1919(h) and CMS regulations at 42 CFR 488.417, CMS may impose a DPNA against a SNF when a facility is not in substantial compliance with requirements of participation.

Medicare policy indicates that beneficiaries admitted before the effective date of a DPNA situation and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are not considered new admissions, and **are not subject to the denial of payment upon return.**

Medicare instructions previously indicated that SNFs should append a condition code 57 (SNF readmission) for those patients in which the DPNA does not apply. However, the definition for condition code 57 indicates the patient previously received Medicare covered SNF care within 30 days of this readmission and would not necessarily apply in all payment ban situations.

For example, a readmission could apply to patients that resided in the SNF prior to the imposition of the ban, whether on private pay or covered under another insurer, then went out to a hospital for a qualifying stay and returned directly back to the SNF upon discharge of the hospital. If the patient, in this scenario, did not receive Medicare SNF covered care within 30 days of the readmission then the condition code 57 would not be appropriate.

Therefore, CMS is updating DPNA instructions to require SNF providers to append occurrence span code 80 (definition below), for same-SNF readmissions, to indicate the most recent prior same-SNF stays dates of the patient prior to their discharge to the hospital for a qualifying hospital stay. **As long as the patient resides in the SNF prior to the imposition of a payment ban and the patient discharges to the hospital then directly back to the same**

**SNF from the hospital the claim would be considered a readmission for DPNA purposes and a payment ban will not be applicable.**

In addition, if the patient resides in the SNF prior to the imposition of the ban and goes on a LOA, the patient will not be subject to a ban upon their return to the SNF should a payment ban be applicable during their return. Providers must be sure to bill the LOA period on their claim.

### **Key Points of CR6116**

Chapter 6, Section 50 of the Medicare Claims Processing Manual covers SNF payment bans and related DPNA actions. That section is revised by CR6116 as follows:

#### ***Billing for Admissions Not Covered by the Payment Ban***

Effective January 1, 2009, when a SNF that is under a payment ban needs to submit a claim for a Medicare beneficiary readmission that is not subject to the payment ban, the SNF must use **occurrence span code 80 for reporting prior same-SNF stay dates**. The definition of "Prior Same-SNF Stay Dates for Payment Ban Purposes" is: **The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.** (Previously, SNFs used condition code 57 for this purpose, but that code does not apply to all payment ban situations.)

#### ***Effect on Utilization Days and Benefit Period***

In situations where the beneficiary's SNF admission is subject to the payment ban, but the **provider fails to issue the proper beneficiary liability notice, the provider is liable** for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts from the beneficiary. **These days will be charged against the patient's utilization** as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.).

If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

#### ***Effect of an Appeal to A DPNA on Billing during the Period the SNF Is Subject to a DPNA***

In those situations where the SNF decides to appeal the imposition of a DPNA, it must still bill the program as set forth in the provider liability billing instructions in the revised Section 50, which is attached to CR6116. In essence, the SNF needs to file a covered bill with the FI or A/B MAC using occurrence span code 77 that indicates the facility is liable for the services in situations where the SNF failed to issue the proper beneficiary liability notice and any applicable copayments will be charged to the beneficiary's Part A benefit period. In addition, the SNF needs to file a non-payment bill for non-covered Part A services using **condition code 21 that indicates beneficiary liability**. Remember that services that would have been eligible for Part A benefits in the absence of sanctions may not be billed as Part B charges to Medicare.

#### ***Conducting Resident Assessments***

If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, no payment is made and the SNF must submit a claim using the Health Insurance Prospective Payment System (HIPPS) default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

When the SNF does not receive timely notification that a payment ban has been lifted, and staff is unaware of the need to start the Medicare-Required schedule (the beneficiary meets all applicable eligibility and coverage requirements), the SNF may bill the Medicare 5-day and 14 day assessment using the HIPPS code generated by the 14-day Omnibus Budget Reconciliation Act (OBRA) required assessment. If the SNF did not perform any assessments with an assessment reference date during the assessment window for the Medicare-Required five day or 14 day assessment, the SNF must bill the default rate for those covered days associated with the assessment. Where the SNF did not perform an assessment with an assessment reference date (ARD) that fell in the applicable Medicare-Required Assessment window for the 30, 60 and 90 day Medicare-Required Assessments it shall bill the default rate. If the SNF did perform an assessment, including a Significant Change in Status Assessment (SCSA), where the ARD fell in the window of a 30, 60 or 90-day Medicare-Required Assessment (including grace days), the SNF shall bill using the HIPPS code generated from the assessment in accordance with the payment policies found in Chapter 28 of the Provider Reimbursement Manual. The date the sanction is lifted is Day ONE for purposes of the Medicare assessment schedule.

**Example 1:** The SNF is notified on June 15th that its payment ban was lifted effective June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the five-day Medicare-Required Assessment for up to 14 days. Day 15 is day 1 for purposes of starting the Medicare-required assessment schedule and a five-day Medicare required assessment shall be performed.

**Example 2:** The SNF is notified on August 15 that its payment ban was lifted on June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA Assessment. The initial OBRA assessment shall be used to bill the five -day Medicare required assessment and the 14-day Medicare required assessment. The 30-day assessment may be billed through day 44 at the default rate. Day 45 is day 1 for purposes of starting the Medicare- required assessment schedule and a five-day Medicare required assessment shall be performed.

### Additional Information

For complete details regarding this CR please see the official instruction (CR6116) issued to your Medicare contractor. Current Medicare instructions for DPNA billing reside in sections 50-50.7 of Chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual*. These sections are revised by CR6116 and you may review these revised sections in the attachment to this CR 6116 at

<http://www.cms.hhs.gov/Transmittals/downloads/R1555CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at

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

**Comprehensive Error Rate Testing (CERT)****CERT ALERT: HANDLING A PROVIDERS' ALLEGATION OF RECORD DESTRUCTION**

With the recent widespread flood damage to many communities in the Midwest, there may be cases where medical records are damaged, destroyed, or are temporarily unavailable to health care providers. This may greatly impact the ability of providers to respond to the CERT Contractor's requests for medical records.

In these situations, the CERT Documentation Contractor and the CERT Review Contractor will check various public and commercial sources to verify the facts surrounding claims that CERT-requested medical records were destroyed by a disaster. For CERT purposes, a "disaster" is defined as any natural or man-made catastrophe which causes damages of sufficient severity and magnitude **to partially or completely destroy or delay access to medical records and associated documentation**. Natural disasters would include hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, tsunamis. Man-made disasters would include terrorist attacks, bombings, floods caused by man-made actions, civil disorders, or explosions. When the CERT Documentation Contractor is contacted by a provider indicating that they cannot submit the requested medical records because they were destroyed by a disaster, the CDC will ask the provider to attest under penalty of perjury to the destruction of medical records.

**A provider attestation form has been created for use in these instances. Providers who need to use this attestation form can print and fax the form to the CERT Documentation Contractor at 240-568-6222. This form is also available on the CERT Provider Website at: <http://www.certcdc.com/certproviderportal/attestationLetter.aspx>**

For more information on the Centers for Medicare & Medicaid Services (CMS) response to the current situation, please visit their Website at [http://www.cms.hhs.gov/emergency/20\\_midwestflooding.asp](http://www.cms.hhs.gov/emergency/20_midwestflooding.asp)

**Coverage – General****CARDIAC COMPUTED TOMOGRAPHIC ANGIOGRAPHY (CTA)  
~CMS MLN Matters~**

MLN Matters Number: MM6098

Related CR Release Date: June 27, 2008

Related CR Transmittal #: R85NCD

Related Change Request (CR) #: 6098

Effective Date: March 12, 2008

Implementation Date: July 28, 2008

**Provider Types Affected**

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

**Provider Action Needed**

This article is informational only and based on Change Request (CR) 6098 which announces that the Centers for Medicare & Medicaid Services (CMS), upon review of the available evidence, has determined that the coverage of cardiac computed tomographic angiography (CTA) to diagnosis coronary artery disease (CAD) will remain at local Medicare contractor discretion, and no national coverage determination (NCD) is appropriate at this time.

**Background**

CTA is a noninvasive method (using intravenous contrast) to visualize the coronary arteries (or other vessels) using high resolution, high speed computed tomography (CT).

After examining the medical evidence, CMS has determined that no NCD is appropriate at this time, effective March 12, 2008. Pursuant to the Social Security Act (Section 1862(a)(1)(A)), decisions should be made by local contractors through:

- the local coverage determination process, or
- case-by-case adjudication.

Therefore, all claims for CTA used to diagnose CAD will continue to be determined by local Medicare contractor discretion and section 220.1 of Publication 100-03 of the NCD Manual remains unchanged.

**Additional Information**

The official instruction, CR 6098, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R85NCD.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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

**CHANGES TO THE LABORATORY NATIONAL COVERAGE  
DETERMINATION (NCD) EDIT SOFTWARE FOR JULY 2008  
~CMS MLN Matters~**

MLN Matters Number: MM6084 **Revised**

Related Change Request (CR) #: 6084

Related CR Release Date: June 6, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1531CP

Implementation Date: July 7, 2008

**Note:** This article was revised on June 27, 2008, to reflect the re-issuance of CR6084 to show that Medicare contractors use the appropriate ICD-9-CM and CPT codes effective dates, which are October 1, 2007 for the ICD-9-CM codes and January 1, 2008, for the CPT codes. All other information remains the same.

**Provider Types Affected**

Clinical diagnostic laboratories billing Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (AB MACs)).

**Provider Action Needed**

This article is based on Change Request (CR) 6084 which announces the changes that will be included in the July 2008 quarterly release of the edit module for clinical diagnostic laboratory services. The last quarterly release of the edit module was issued in April 2007. CR 6084 incorporates all changes from April 2007 to the present and has no other changes.

**Background**

The National Coverage Determinations (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 the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the Medicare Claims Processing Manual (Chapter 16, Section 120.2; see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) 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. These changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 6084 announces changes to the laboratory edit module for changes in laboratory NCD code lists for July 2008 as described below. These changes become effective for services furnished on or after July 1, 2008.

**Note:** Medicare contractors use the appropriate effective dates for the ICD-9-CM and CPT codes, which are October 1, 2007 for the ICD-9-CM codes and January 1, 2008, for the CPT codes.

Contractors are not required to search their files to adjust affected claims between the July 1, 2007, and the July 1, 2008, quarterly clinical lab edit module updates.

**CR 6084 reports the following changes effective July 1, 2008:****For HIV Testing:**

- Add ICD-9-CM codes 079.83 and 288.66 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (190.14) NCD.
- Modify the descriptor for Current Procedural Terminology (CPT) code 86701 in the HIV Testing (190.14) NCD to read “Antibody; HIV-1.”
- Modify the descriptor for CPT code 86702 in the HIV Testing (190.14) NCD to read “Antibody; HIV-2.”
- Modify the descriptor for CPT code 86703 in the HIV Testing (190.14) NCD to read “Antibody; HIV-1 and HIV-2, single assay.”

**For Blood Counts:**

- Add ICD-9-CM codes 388.45, 389.05, 389.06, 389.13, 389.17, 389.20, 389.21, 389.22, V25.04, V26.41, V26.49, V26.81, V26.89, V49.85 and V72.12 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Delete ICD-9-CM codes 389.2, V26.4 and V26.8 from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Modify the descriptor for ICD-9-CM code 389.14 to read “Central hearing loss” in the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD;
- Modify the descriptor for ICD-9-CM code 389.18 to read “Sensorineural hearing loss, bilateral” in the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD; and
- Modify the descriptor for ICD-9-CM code 389.7 to read “Deaf, non-speaking, not elsewhere classifiable” from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.

**For Prothrombin Time:**

- Add ICD-9-CM codes 415.12, 789.51, 789.59, V12.53, and V12.54 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.
- Delete ICD-9-CM code 789.5 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.

**For Serum Iron Studies:**

- Add ICD-9-CM codes 233.30, 233.31, 233.32, and 233.39 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM code 233.3 from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.

**For Glycated Hemoglobin/Glycated Protein:**

- Add ICD-9-CM codes 258.01, 258.02 and 258.03 to the list of ICD-9-CM codes covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- Delete ICD-9-CM code 258.0 from the list of ICD-9-CM codes covered by Medicare for Glycated Hemoglobin/Glycated Protein (190.21) NCD.

**For Thyroid Testing:**

- Add ICD-9-CM codes 255.41, 255.42, 258.01, 258.02, 258.03, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29, 789.51 and 789.59 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM codes 255.4, 258.0, 787.2 and 789.5 from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.

**For Gamma Glutamyl Transferase:**

- Add ICD-9-CM codes 359.21, 359.22, 359.23, 359.24 and 359.29 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM code 359.2 from the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

**For Hepatitis Panel/Acute Hepatitis Panel:**

- Delete ICD-9-CM code 999.3 from the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

**For Fecal Occult Blood Test:**

- Add ICD-9-CM codes 569.43, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29, 789.51 and 789.59 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Delete ICD-9-CM codes 787.2 and 789.5 from the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Modify the descriptor for ICD-9-CM code 005.1 in the Fecal Occult Blood Test (190.34) NCD to read "Botulism food poisoning."
- Modify the descriptor for CPT code 82272 in the Fecal Occult Blood Test (190.34) NCD to read "Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening."

**Additional Information**

The official instruction, CR 6084, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1531CP.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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

## **INTRACRANIAL PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA) WITH STENTING**

~CMS MLN Matters~

**MLN Matters Number: MM6137**

**Related CR Release Date: July 11, 2008**

**Related CR Transmittal #: R87NCD**

**Related Change Request (CR) #: 6137**

**Effective Date: May 12, 2008**

**Implementation Date: August 11, 2008**

**Provider Types Affected**

Physicians and providers who may wish to submit claims to Medicare Carriers, fiscal intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs) for PTA with stenting.

**What Providers Need to Know**

Be aware that the Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and on May 12, 2008 posted a final decision memorandum following reconsideration of its National Coverage Determination (NCD) on PTA with intracranial stent placement at section 20.7.B.5 of the Medicare NCD Manual. With CR6137, **CMS reaffirms its existing NCD with no changes, and will continue to cover PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis  $\geq$  50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials.** CMS will continue its national non-coverage for all other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries.

**Background**

This article is based on Change Request (CR) 6137, which responds to a request on August 24, 2007 by the manufacturer to reconsider and expand coverage to include Coverage with Evidence Development (CED) for intracranial stenting and angioplasty for patients in the IDE clinical trials.

**Additional Information**

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

You may see the official instruction (CR6137) issued to your Medicare Carrier, FI, or A/B MAC, by going to <http://www.cms.hhs.gov/Transmittals/downloads/R87NCD.pdf> on the CMS Website. Section 20.7 of the Medicare NCD Manual is attached to CR6137.

You may also review MM5432 which preceded this article and provides the previous CMS response to PTA with stenting at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5432.pdf> on the CMS Website.

**SCREENING PELVIC EXAMINATION**

~CMS MLN Matters~

MLN Matters Number: MM6085

Related CR Release Date: June 20, 2008

Related CR Transmittal #: R1541CP

Related Change Request (CR) #: 6085

Effective Date: September 23, 2008

Implementation Date: September 23, 2008

**Provider Types Affected**

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), and Medicare Administrative Contractors (A/B MAC)) for providing screening pelvic examinations for Medicare beneficiaries.

**What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) has become aware that the *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 40 (Screening Pelvic Examinations) is not clear on what elements are needed during a screening pelvic examination. CR 6085, from which this article is taken, clarifies this unclear information, specifically adding the following language (displayed below in bolded, underlined italics):

- “Section 4102 of the Balanced Budget Act of 1997 (P.L. 105-33) amended §1861(nn) of the Act (42 USC 1395X(nn)) to include Medicare Part B coverage of screening pelvic examinations ***(including a clinical breast examination)*** for all female beneficiaries for services provided January 1, 1998 and later; and
- A screening pelvic examination ***with or without specimen collection for smears and cultures***, should include at least seven of the following ***eleven*** elements:
  - Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
  - Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses.
  - External genitalia (for example, general appearance, hair distribution, or lesions);
  - Urethral meatus (for example, size, location, lesions, or prolapse);
  - Urethra (for example, masses, tenderness, or scarring);
  - Bladder (for example, fullness, masses, or tenderness);
  - Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
  - Cervix (for example, general appearance, lesions or discharge)
  - Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
  - Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
  - Anus and perineum.

Please note that CR 6085 does not provide any change in policy. It simply clarifies unclear information in the manual as stated above.

**Additional Information**

You can find more information about screening pelvic examinations by going to CR 6085, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1541CP.pdf> on the CMS Website. You will find the updated *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 40 (Screening Pelvic Examinations) as an attachment to CR 6085.

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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

**Coverage – Policies**

**LCD Retirement of policies – for Legacy A providers**

**Contractor Name:**

Mutual of Omaha Insurance Company (transitioned to Wisconsin Physicians Service)

**LCD Database Number(s) and LCD Title:**

- L20620 Clinically Complex Resource Utilization Group (RUGIII): SNF
- L20622 Extensive Services Resource Utilization Group (RUGIII): SNF
- L20616 Impaired Cognition/Behavior/Reduced Physical Function (RUIII): SNF
- L22562 Rehabilitation, Plus Extensive Services: SNF
- L20618 Rehabilitative Services Resource Utilization Group (RUGIII): SNF
- L20624 Special Care Resource Utilization Group (RUGIII): SNF

**Retirement Effective Date:**

August 1, 2008

The policies affect the Legacy A providers.

**INFORMATION ON WEBSITE**

WPS Medicare publishes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), as well as retired LCDs/Local Medical Review Policies (LMRPs) for Medicare Part A on its Website:

[http://www.wpsmedicare.com/part\\_a/policy/index.shtml](http://www.wpsmedicare.com/part_a/policy/index.shtml)

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

**Part A Legacy**  
 WPS Medicare  
 Medicare Medical Review  
 Attn: Medical Review Supervisor  
 P.O. Box 1602  
 Omaha, NE 68101



**Revised Policies for August 2008**

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
DL19866	<i>Immune Globulins</i>	LCD	Click here to view	32
DL2403	<i>Psychiatric Partial Hospitalization Program</i>	LCD	Click here to view	33

**Coverage – Revised Policies****Draft LCD for Immune Globulins \*(formerly Intravenous Immune Globulin IVIG)****Contractor Name**

Mutual of Omaha Insurance Company (transitioned to Wisconsin Physicians Service)

**Contractor Number**

52280

**Contractor Type**

FI

**LCD ID Number**

DL19866

**LCD Title**

Immune Globulins \*(formerly Intravenous Immune Globulin IVIG)

**Contractor's Determination Number**

INJ-012A

**\*INTRODUCTION**

\*Immune serums (immune globulin) provide passive immunity to infectious disease. The protection will be of rapid onset, but of short duration (1-3 months). Immune sera are obtained from pooled human plasma of either general population donors or hyperimmunized donors. It may be administered either by intravenous (IV) or intramuscular (IM) injection.

Start Date of Comment Period

06/26/2008

End Date of Comment Period

08/11/2008

This is a Legacy A LCD revision. Please review revision explanation section on draft LCD for changes.

**Draft LCD for Psychiatric Partial Hospitalization Program\* (DL2403)****Contractor Name**

Mutual of Omaha Insurance Company (transitioned to Wisconsin Physicians Service)

**Contractor Number**

52280

**Contractor Type**

FI

**LCD ID Number**

DL2403

**LCD Title**

Psychiatric Partial Hospitalization Program

**Contractor's Determination**

PSYCH – 02A/2001-02

**\*INTRODUCTION**

Psychiatric partial hospitalization is a distinct and organized intensive psychiatric outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with acute mental illness in order to avoid inpatient care through this type of ambulatory care. The Medicare psychiatric partial hospitalization benefit was established and is intended to furnish services in lieu of inpatient psychiatric care. Partial Hospitalization requires admission and certification of need by a psychiatrist or physician (MD/DO) trained in the diagnosis and treatment of psychiatric illness. Partial hospitalization programs (PHPs) differ from inpatient hospitalization in the lack of 24-hour observation, and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multidisciplinary team, with the patient's involvement.

Start Date of Comment Period

06/26/2008

End Date of Comment Period

08/11/2008

This is a Legacy A LCD revision. Please review revision explanation section on draft LCD for changes.

**Provider Education****EDUCATION SCHEDULE**

Please visit the WPS Medicare Education Schedule at [http://www.wpsmedicare.com/part\\_a/education/seminars.shtml](http://www.wpsmedicare.com/part_a/education/seminars.shtml) and [http://www.wpsmedicare.com/part\\_a/education/teleconferences.shtml](http://www.wpsmedicare.com/part_a/education/teleconferences.shtml) to learn more about the educational events we have scheduled for the upcoming months.

Coming up, we will host events such as:

- Skilled Nursing Facility (SNF) Billing/Compliance Seminar

We hope you can join us to learn more about the Medicare program.

**Reimbursement****JULY 2008 UPDATE OF THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)**

~CMS MLN Matters~

MLN Matters Number: MM6094

Related Change Request (CR) #: 6094

Related CR Release Date: June 19, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1536CP and R90BP

Implementation Date: July 7, 2008

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on CR6094, which describes changes to, and billing instructions for various payment policies implemented in the July 2008 OPSS update. The July 2008 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 notification.

The July 2008 revisions to the I/OCE data files, instructions, and specifications are discussed in MLN Matters article MM6080, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6080.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. Be sure your billing staff is aware of these changes.

**Background**

Following are the key changes effective for July 1, 2008 update of the OPSS:

***Applicability of OPSS to Specific HCPCS Codes***

Current Procedural Terminology (CPT) codes generally are created to describe and report physician services, but are also used by other providers/suppliers to describe and report services that they provide. Therefore, the CPT code descriptors do not necessarily reflect the facility component of a service furnished by the hospital. Some CPT code descriptors include reference to a physician performing a service. For OPSS purposes, unless indicated otherwise, the usage of the term "physician" does not restrict the reporting of the code or application of related policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure.

***Changes to Procedure and Device Edits for July 2008***

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. 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 “2008 Device and Procedure Edits” at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS Website.

### **Payment for Brachytherapy Sources as of July 1, 2008**

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for brachytherapy sources for the period of January 1 through June 30, 2008, at hospitals' charges adjusted to the costs. Therefore, the CMS is paying for brachytherapy sources based on charges adjusted to cost through June 30, 2008, and CMS will pay at prospective rates as of July 1, 2008. The prospective payment rates for each source, which are listed in Addendum B to the CY 2008 final rule dated November 27, 2007, will be used for payment from July 1 through December 31, 2008. (Addendum B is available at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS Website.) The “H” payment status indicators of brachytherapy source HCPCS codes (except C2637), which were previously paid at charges adjusted to cost, will change to payment status indicator “K” effective July 1, 2008 through December 31, 2008.

In addition, because the sources will be paid based on prospective rates as of July 1, brachytherapy sources will be eligible for outlier payments and for the rural sole community hospital (SCH) adjustment as of July 1, 2008. The HCPCS codes for separately payable brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 1 below, a comprehensive list of payable brachytherapy sources. Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See MLN Matters article MM5623 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5623.pdf> for further information on billing for brachytherapy sources and the OPSS coding changes made for brachytherapy sources effective July 1, 2007.

**Table 1- Comprehensive List of Brachytherapy Sources Payable as of July 1, 2008**

CPT/ HCPCS	Long Descriptor	**SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	K	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	K	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	K	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	K	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	K	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	K	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	K	2635

C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	K	2636
C2638	Brachytherapy source, stranded, Iodine-125, per source	K	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	K	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	K	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	K	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	K	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	K	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	K	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	K	2699

\*\* SI (Status Indicator)

### **Continuous Positive Airway Pressure (CPAP) Therapy**

CMS revised its National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA). CMS now allows coverage of CPAP when used in adult patients diagnosed with obstructive sleep apnea (OSA) by home sleep testing (HST). This revised coverage became effective for claims with dates of service on and after March 13, 2008. Information on the criteria for coverage under this revised NCD can be found in section 240.4 of the NCD Manual, available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website. To adequately report the home sleep study test for CPAP therapy, CMS has created the following three G-codes. Under OPSS, the G-codes have been assigned to APC 0213 (Level I Extended EEG and Sleep Studies). Payment rates for these services can be found in Addendum B of the July 2008 OPSS Update that is posted on the CMS Website.

**Table 2-Home Sleep Study Tests for Continuous Positive Airway Pressure (CPAP) Therapy Services that are Effective July 1, 2008**

HCPCS	Long Descriptor	APC	SI
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	0213	S
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	0213	S
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	0213	S

### **Category III CPT Codes**

The American Medical Association (AMA) releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, CMS implemented new Category III CPT codes once a year in January of the following year. As discussed in the CY 2006 OPSS final rule with comment period (70 FR 68567), CMS modified the process for implementing the Category III

codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by CMS in response to applications for new technology services. Therefore, on July 1, 2008, CMS implemented in the OPPS five Category III CPT codes that the AMA released in January 2008 for implementation in July 2008. The codes, along with their status indicators and APCs, are shown in Table 3 below. Payment rates for these services can be found in Addendum B of the July 2008 OPPS Update that is posted on the CMS Website.

**Table 3--Category III CPT Codes Implemented as of July 1, 2008**

HCPCS	Long Descriptor	APC	SI
0188T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30- 74 minutes	N/A	M
0189T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes	N/A	M
0190T	Placement of intraocular radiation source applicator	0237	T
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach	0234	T
0192T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach	0234	T

#### **Cardiac Echocardiography With Contrast (C8921 - C8928)**

In the April 2008 update to the OPPS, CMS listed the revised short and long descriptors for the eight new C-codes for cardiac echocardiography with contrast services that were effective January 1, 2008. The codes, along with the revised short and long descriptors, were listed in Table 3. Unfortunately, the long descriptors for C8922 and C8924 were incorrect in Table 3. The correct short and long descriptors for the eight C-codes for cardiac echocardiography with contrast services were posted on the CMS HCPCS Website, specifically at [http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02\\_HCPCS\\_Quarterly\\_Update.asp#TopOfPage](http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage) on the CMS Website. Refer to the April 2008 HCPCS C-codes list dated March 25, 2008.

**Hospitals are advised to download this file to view the correct long descriptors for C8922 and C8924.**

#### **Billing for Drugs, Biologicals, and Radiopharmaceuticals**

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS 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 OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the

New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

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

**a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2008**

In the CY 2008 OPSS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (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 2008 release of the OPSS PRICER. The updated payment rates effective July 1, 2008, will be included in the July 2008 update of the OPSS Addendum A and Addendum B, which will be posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS Website shortly.

**b. Drugs and Biologicals with OPSS Pass-Through Status Effective July 1, 2008**

Six drugs have been granted OPSS pass-through status effective July 1, 2008. These drugs, their descriptors, and APC assignments are identified in Table 4 below.

**Table 4- Drugs Granted Pass-Through Status Effective July 1, 2008**

HCPCS	Long Descriptor	SI	APC
C9242*	Injection, fosaprepitant, 1 mg	G	9242
C9356*	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	G	9356
C9357*	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	G	9357
C9358*	Dermal substitute, native, non-denatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9358
J1571	Injection, hepatitis b immune globulin (Hepagam b), intramuscular, 0.5 ml	G	0946
J1573	Injection, hepatitis b immune globulin (Hepagam b), intravenous, 0.5 ml	G	1138

**Note:** Those HCPCS codes identified with a "\*" indicate that they are new codes effective July 1, 2008.

**c. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2007 through December 31, 2007**

The payment rates for several HCPCS codes were incorrect in the October 2007 OPPS Pricer. The corrected payment rates are listed below and have been installed in the July 2008 OPPS Pricer, effective for services furnished on October 1, 2007, through implementation of the January 2008 update. Your Medicare contractor will adjust any claims that you bring to their attention that were not processed correctly due to the incorrect rates in the October 2007 OPPS Pricer.

**Table 5- Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2007 through December 31, 2007**

HCPCS	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	121.28	24.26
90675	9139	Rabies vaccine, im	152.82	30.56
J0637	9019	Caspofungin acetate	24.29	4.86
J1562	0804	Vivaglobulin, injection	7.01	1.40
J9015	0807	Aldesleukin/single use vial	758.15	151.63

**d. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008**

The payment rates for several HCPCS codes were incorrect in the January 2008 OPPS Pricer. The corrected payment rates are listed below and have been installed in the July 2008 OPPS Pricer, effective for services furnished on January 1, 2008, through implementation of the April 2008 update. Your Medicare contractor will adjust any claims that you bring to their attention that were not processed correctly due to the incorrect rates in the January 2008 OPPS Pricer.

**Table 6- Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008**

HCPCS	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90675	9139	Rabies vaccine, im	150.27	30.05
J2820	0731	Sargramostim injection	25.02	5.00
J9010	9110	Alemtuzumab injection	549.29	109.86
J9015	0807	Aldesleukin/single use vial	764.56	151.47
J9226	1142	Supprelin LA implant	14694.12	2938.82

**e. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008**

The payment rates for several HCPCS codes were incorrect in the April 2008 OPPS Pricer. The corrected payment rates are listed below and have been installed in the July 2008 OPPS Pricer, effective for services furnished on April 1, 2008, through implementation of the July 2008 update. Your Medicare contractor will adjust any

claims that you bring to their attention that were not processed correctly due to the incorrect rates in the April 2008 OPSS Pricer.

**Table 7- Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008**

HCPCS	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J2323	9126	Natalizumab injection	7.51	1.49
J2778	9233	Ranibizumab inj	406.18	80.47
J3488	0951	Reclast injection	216.61	42.91

**f. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices**

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

**g. Correct Reporting of Units for Drugs**

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS 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, bill 10 units, even though only 1 vial was administered. 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.

**h. Changes to Payment for Therapeutic Radiopharmaceuticals for July 2008**

The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007, Pub. L. No. 110-173 amended the Medicare statute and provided a continuation of payment for therapeutic radiopharmaceuticals based on individual

hospital charges adjusted to cost from January 1 through June 30, 2008. Therefore, in accordance with the statute, finalized CY 2008 prospective payment rates for therapeutic radiopharmaceuticals were not implemented in the OPPS during this time period. However, the statute expires on June 30, 2008, and, as such, the finalized payment prospective payment rates go into effect on July 1, 2008.

Therefore, payment for separately payable therapeutic radiopharmaceuticals under the OPPS will be made on a prospective basis, with payment rates based upon mean costs from hospital claims data as set forth in the CY 2008 OPPS/ASC final rule (72 FR 66772), beginning on July 1, 2008.

**Table 8-Therapeutic Radiopharmaceuticals that are Separately Payable Effective July 1, 2008**

HCPCS	Long Descriptor	SI	APC
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	K	1064
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	K	1150
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	K	1643
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	K	1645
A9563	Sodium phosphate P-32, therapeutic, per millicurie	K	1675
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	K	1676
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	K	0701
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	K	0702

**i. Changes to Nuclear Medicine Procedure to Radiopharmaceutical Edits for July 2008**

Effective January 1, 2008, under the OPPS, payment for diagnostic radiopharmaceuticals is packaged into payment for their associated nuclear medicine procedures. In order to ensure that appropriate diagnostic radiopharmaceutical costs for future rate setting purposes was captured, CMS implemented edits in the I/OCE effective January 2008 that required a diagnostic radiopharmaceutical to be present on the same claim as a nuclear medicine procedure.

As is the standard process for edit lists under the OPPS, CMS reviews the appropriateness of the edits and considers modifying the edits quarterly as issues are brought to their attention. In April 2008, in response to several descriptions of specific clinical scenarios provided to CMS by members of the public, CMS added HCPCS code A9517 (Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie) to their list of radiopharmaceuticals that would be accepted for a nuclear medicine procedure claim to process.

Since the change to the edit list was adopted for the April update, CMS has received several descriptions of clinical scenarios where a therapeutic radiopharmaceutical or a brachytherapy source is provided to a patient by a hospital and a nuclear medicine procedure follows, without administration of a diagnostic radiopharmaceutical. Members of the public bringing these situations to the attention of CMS state that situations where these radiolabeled products would be used without a diagnostic

radiopharmaceutical would be rare, but are sufficiently common that hospitals require a methodology to appropriately bill and be paid for the associated nuclear medicine procedures. As a result of these requests, for the July 2008 update CMS has included the HCPCS codes for all diagnostic radiopharmaceuticals, therapeutic radiopharmaceuticals, and brachytherapy sources as radiolabeled products that may be reported on a claim with nuclear medicine procedures to satisfy the edit requirements. CMS expects that the majority of nuclear medicine procedures will be performed with diagnostic radiopharmaceuticals, and that it will be only in uncommon circumstances that hospitals would report nuclear medicine procedures with therapeutic radiopharmaceuticals or brachytherapy sources. CMS will be monitoring claims to ensure that this is the case.

Therefore, beginning in July 2008, claims for nuclear imaging procedures reported with any of the HCPCS codes for diagnostic radiopharmaceuticals, therapeutic radiopharmaceuticals, or brachytherapy sources will not be returned to the provider as the nuclear medicine procedure and radiolabeled product are included on the same claim.

**Note:** Hospitals are only to report HCPCS codes for products they administer and should not be reporting a token charge for a radiolabeled product on the edit list solely for the purpose of bypassing edits present in the I/OCE.

The complete list of updated edits can be found at [http://www.cms.hhs.gov/HospitalOutpatientPPS/02\\_device\\_procedure.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage) on the CMS Website.

### ***Hospital Services for Patients with End Stage Renal Disease (ESRD)***

CMS is revising the Medicare Claims Processing Manual, Chapter 4, Section 200.2 to expand the circumstances under which payment may be made to a hospital for unscheduled outpatient dialysis provided to an ESRD patient. The first circumstance listed is “dialysis performed following or in connection with a vascular access procedure.” CMS is expanding this to include any dialysis related procedure such as vascular access procedures or blood transfusions, and the revised Chapter 4 (Section 200.2) of the Medicare Claims Processing Manual is included as an attachment to CR 6094.

### ***Coverage of Outpatient Therapeutic Services Incident to a Physician’s Service Furnished on or After August 1, 2000***

CMS is revising the Medicare Benefit Policy Manual, Chapter 6, Section 20.5.1 to remove language stating that services furnished in provider-based departments of hospitals must be rendered under the direct supervision of a physician “who is treating the patient.” While this “treating the patient” language has been a part of the manual for several years, recent revisions made to Section 20.5.1 in Transmittal 82/CR 5946 (February 8, 2008) have caused confusion related to the context and application of this phrase in relation to the requirements of the Code of Federal Regulations. The revised Chapter 6 (Section 20.5.1) of the Medicare Benefit Policy Manual is included as an attachment to CR 6094.

### ***Coverage Determinations***

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPTS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. FIs/AB MACS will

determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FI/MACs will determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

**Additional Information**

The official instruction, CR 6094, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1536CP.pdf> on the CMS Website. The modified section of the Medicare Benefit Policy Manual regarding coverage of outpatient therapeutic services incident to physician's services is available at <http://www.cms.hhs.gov/Transmittals/downloads/R90BP.pdf> on the same site.

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

**UPDATE-INPATIENT PSYCHIATRIC FACILITIES PROSPECTIVE  
PAYMENT SYSTEM (IPF PPS) RATE YEAR 2009  
~CMS MLN Matters~**

**MLN Matters Number: MM6077**

**Related Change Request (CR) #: 6077**

**Related CR Release Date: June 27, 2008**

**Effective Date: July 1, 2008**

**Related CR Transmittal #: R1543CP**

**Implementation Date: July 7, 2008**

**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

**What You Need to Know**

Change Request (CR) 6077, from which this article is taken, identifies changes that are required as part of the annual inpatient psychiatric facilities prospective payment system (IPF PPS) update for RY 2009. These changes include the market basket update, Pricer updates for IPF PPS rate year (RY) 2009, (July 1, 2008 – June 30, 2009), the stop-loss provision, the electroconvulsive therapy (ECT) update, the payment rate, the national urban and rural cost to charge ratios (CCRs) for the IPF PPS RY 2008, the MS DRG update, and the cost-of-living adjustment (COLA) for Alaska and Hawaii.

These changes are effective July 1, 2008, and are applicable to IPF discharges occurring during the rate year beginning on July 1, 2008, through June 30, 2009.

In addition, CR 6077 corrects the IPF PPS Pricer to include diagnosis code 07070 (Viral Hepatitis C without Hepatic Coma) in calculating a comorbidity adjustment for claims with discharge dates on or after January 1, 2005 through June 30, 2006.

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

**Background**

Under the IPF PPS, payments to inpatient psychiatric facilities are based on a Federal Per Diem base rate that:

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

CMS is required to update this IPF PPS annually. The Rate Year (RY) update is effective July 1 - June 30 of each year and the Medicare Severity Diagnosis Related Groups (MS-DRG) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

CR 6077, from which this article is taken, identifies changes that are required as part of the annual IPF PPS update from the RY 2009 IPF PPS update notice, published on May 7, 2008. These changes, which are applicable to IPF discharges occurring during the rate year beginning on July 1, 2008, through June 30, 2009, are presented below.

**Market Basket Update**

CMS uses the **Rehabilitation/Psychiatric/Long-Term Care (RPL)** market basket to update the IPF PPS portion of the blended payment rate (that is the Federal per diem base rate).

**PRICER Updates: For IPF PPS Rate Year (RY) 2009, (July 1, 2008 – June 30, 2009)**

The PRICER updates are as follows:

- The Federal per diem base rate is **\$637.78**;
- The fixed dollar loss threshold amount is **\$6,113.00**;
- The transition from TEFRA to PPS ends in 2008. For cost reporting periods beginning on or after January 1, 2008, payments will be **100% PPS**;
- The IPF PPS will use the FY 2008 unadjusted pre-floor, pre-reclassified hospital wage index; The labor-related share is **75.631%**; the non-labor related share is **24.369%**; and The electroconvulsive therapy (ECT) rate is **\$274.58**.

**Stop-Loss Provision**

To ensure that an IPF's total PPS payments were no less than a minimum percentage of their TEFRA payment (had the IPF PPS not been implemented), CMS provided a stop-loss payment during the transition from cost-based reimbursement to the per diem payment system. Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100% IPF PPS and, therefore, the stop loss provision will no longer be applicable, and the 0.39% adjustment to the Federal per diem base rate will be removed. Therefore, for RY 2009, the Federal per diem base rate and ECT rates will be increased by 0.39%. The rates published in CR 6077 include this increase.

**Electroconvulsive Therapy (ECT) Update**

The update methodology for the ECT rate is to update the previous rate year's amount by the market basket increase, wage index budget neutrality factor and stop-loss premium removal. For RY 2009, the ECT adjustment per treatment is **\$274.58**.

**Payment Rate**

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). The RY 2009 rates (displayed in Table 1, below) were published in the update notice and can also be found at <http://www.cms.hhs.gov/InpatientPsychFacilPPS> on the CMS Website.

**Table 1**  
**RY2009 IPF PPS Per Diem Rate**

Federal Per Diem Base Rate	\$637.78
Labor Share (0.75631)	\$482.36
Non-Labor Share (0.24369)	\$155.42

**The National Urban and Rural Cost to Charge Ratios (CCR) for the IPF PPS RY 2009**

Table 2 below displays the CCRs for RY 2009.

**Table 2**

Cost to Charge Ratio	Median	Ceiling
Urban	0.537	1.6724
Rural	0.686	1.8041

Please note that the national median CCRs are being applied to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, these national ratios will be used 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.
- IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the Medicare FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

**MS-DRG Update**

Since the IPF PPS uses the same GROUPER as the inpatient prospective payment system (IPPS) (including the same diagnostic code set and DRG classification system), the IPF PPS is adopting IPPS' new MS-DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note these are the same adjustment factors that have been in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Table 3, below, displays the crosswalk of current DRGs to the new MS-DRGs which were effective October 1, 2007:

**Table 3  
DRG to MS-DRG Crosswalk  
Effective October 1, 2007**

(v24) DRG Prior to 10/01/07	(v25) MS-DRG After 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521- 522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

#### **Issue Unrelated to the RY 2009 IPF PPS Update**

In addition to the aforementioned RY 2009 updates, CMS identified an error within the IPF PPS Pricer that did not calculate a comorbidity adjustment (adjustment factor 1.07) on claims that contained both diagnosis code 07070 and a discharge date occurring on or after January 1, 2005 through June 30, 2006. CR 6077 announces that this error will be corrected in the release of the RY 09 Pricer. Medicare FIs and A/B MACs will reprocess and finalize any claim affected by this error, if you bring it to their attention.

#### **Additional Information**

You can find more information about the RY 2009 update to the IPF PPS by going to CR 6077, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1543CP.pdf> on the CMS Website.

You will find updated *Medicare Claims Processing Manual* Chapter 3 (Inpatient Hospital Billing) Sections 190.4.2.1 (Budget Neutrality Components), 190.5 (Patient-Level

Adjustments), 190.5.1 (Diagnosis- Related Groups (DRGs) Adjustments), 190.5.2 (Application of Code First, 190.6.5 - Cost-of-Living Adjustment (COLA) for Alaska and Hawaii), 190.7.3 (Electroconvulsive Therapy (ECT) Payment), 190.7.4 (Stop Loss Provision (Transition Period Only)), 190.10.1 (General Rules), and 190.17.1 (Inputs/Outputs to PRICER) as an attachment to CR 6077.

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

**UPDATE-LONG TERM CARE HOSPITAL (LTCH) PROSPECTIVE  
PAYMENT SYSTEM (PPS) FOR RATE YEAR (RY) 2009  
~CMS MLN Matters~**

**MLN Matters Number: MM6114**

**Related CR Release Date: July 3, 2008**

**Related CR Transmittal #: R1547CP**

**Related Change Request (CR) #: 6114**

**Effective Date: July 1, 2008**

**Implementation Date: July 7, 2008**

**Provider Types Affected**

Long term care hospitals (LTCHs) claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services paid under the LTCH PPS that are provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 6114 which announces changes to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) for Rate Year (RY) 2009. Be sure billing staff is ware of this update.

**Background**

On October 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented the LTCH PPS under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. See the Federal Register, Vol. 67, No. 169, August 30, 2002 at [http://www.access.gpo.gov/su\\_docs/fedreg/a020830c.html](http://www.access.gpo.gov/su_docs/fedreg/a020830c.html) on the internet.

Payments under this LTCH PPS are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data.

CMS is required to update the payments made under the LTCH PPS annually, and since 2004 there have been two significant LTCH PPS updates each year:

1. The Federal payment rates update that occur in July of each year (the Rate Year (RY) cycle), and
2. The LTC-DRG update that occurs in October of each year.

**R Y2009 Payment Updates**

In the RY 2009 final rule, CMS established a policy to consolidate these two annual update cycles such that the annual updates to both the Federal payment rates and the medical severity LTC-DRGs (MS-LTC-DRGs) will occur on October 1 of each year, beginning with October 1, 2009.

To begin this change, RY 2009 will be a 15-month rate year (from July 1, 2008 through September 30, 2009), and all updates to the PRICER for RY 2009 will be made based on calculations reflecting this change.

For the LTCH PPS 2009 Rate Year (July 1, 2008 through September 30, 2009):

- The standard Federal rate is \$39,114.36;
- The fixed loss amount is \$22,960;
- The labor-related share is 75.662 percent; and
- The non-labor related share is 24.338 percent.

There is no longer a phase-in of the LTCH PPS wage index adjustment as of cost reporting periods beginning on or after October 1, 2006. Therefore, the wage index table within the PRICER includes only one column that contains the wage index value that will be effective for all LTCH PPS discharges occurring on or after July 1, 2008 through September 30, 2009.

**Short-Stay Outlier (SSO) Payment Adjustment Formula**

On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Therefore, there will be no comparison of the covered length of stay (LOS) of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. For SSO discharges occurring on or after December 29, 2007, and before December 29, 2010, the adjusted payment for a SSO case is equal to the least of:

- 100 percent of estimated cost of the case;
- 120 percent of the LTC-DRG per diem amount;
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007.

CR6114 makes other clarifying language adjustments to Chapter 3, Section 150.9 (Payment Rate) of the Medicare Claims Processing Manual. That revised section is attached to CR6114. The CR is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1547CP.pdf> on the CMS Website.

**Legislative Adjustments to Payment Policy for Co-Located Providers**

For hospitals within hospitals (HwH), satellite facilities, and onsite SNFs, the MMSEA legislation also made several changes for a 3-year period beginning on December 29, 2007. These changes impact the basic payment formula under the 25 percent threshold payment adjustment for Medicare discharges from referring hospitals. These changes are annotated in a revised Chapter 3, Section 150.9.1.4 (Payment Policy for Co-Located Providers), which is attached to CR6114.

***COLA Factors for Alaska and Hawaii***

Also note that in the LTCH Final Rule for RY 2009, the cost of living adjustment (COLA) factors for LTCHs located in Alaska and Hawaii are not revised from their current values, and these current COLA factors will continue to be effective for LTCH PPS discharges occurring on or after July 1, 2008 through September 30, 2009. The COLA factors for Alaska and Hawaii hospitals are shown in the following table.

<b>Alaska and Hawaii Hospitals Area Cost of Living Adjustment Factors Effective for Discharges on and after October 1, 2008</b>	
<b>Alaska</b>	
City of Anchorage and 80-kilometer (50 mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50 mile) radius by road	1.24
City of Juneau and 80-kilometer (50 mile) radius by road	1.24
Rest of Alaska	1.25
<b>Hawaii</b>	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

**Additional Information**

The official instruction, CR 6114, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1547CP.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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

**WPS MEDICARE PROVIDER SERVICES**

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