

# Communiqué

# MAC

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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### Key to Indicators in Table of Contents

A	Article Applies to Part A Only
B	Article Applies to Part B Only
A/B	Article Applies to Both Part A and Part B

**Items of Importance****2009 MEDICARE PHYSICIAN FEE SCHEDULES NOW AVAILABLE****~Part B~**

The 2009 Medicare Physician Fee Schedules are now available on the WPS Medicare Website:

[http://www.wpsmedicare.com/mac/fees/b\\_fees.shtml](http://www.wpsmedicare.com/mac/fees/b_fees.shtml)

Fee information will not be available on the Participation and Enrollment CD-ROM this year; however, we have provided the schedules in Excel and Adobe format in order to meet your needs. To access the Excel files, you need software that can open ZIP files. If you do not currently have unZIP software, please talk to your Systems department for recommendations.

These fees will be valid as of January 1, 2009, and serve as important resources. Please visit the Fees Page for more information.

**Important Note:** To ensure accuracy, effective with the 2009 fees, WPS Medicare will post those fees to our Website that are required per the Centers for Medicare & Medicaid Services (CMS). For all other fees, we now link to the appropriate CMS Web pages.

**2009 PARTICIPATION/ENROLLMENT CD-ROM****~Part B~**

In mid-November, WPS Medicare mailed the 2009 Participation/Enrollment CD-ROM to our Part B providers. This CD-ROM provides you with 2009 Medicare participation information, as well as some other helpful Medicare resources.

On this CD, you will find the following information:

- Information on where to find the 2009 Medicare Physician Fee Schedules
- An article about the CMS Medicare Learning Network
- Medicare Participation Announcement for Calendar Year 2009
- Medicare Participating Physician or Supplier Agreement
- Information regarding unsolicited or voluntary refunds
- WPS Medicare Part B Refund Form
- Provider survey on the 2009 Participation/Enrollment CD-ROM

To access the information on the CD-ROM, simply put the CD into your CD-ROM drive, and the CD menu will automatically pop-up.

**Troubleshooting**

- If the menu does not automatically pop-up on your computer screen, open the CD-ROM drive on your computer, and:
  - PC Users: Open the file titled "autorun.exe"
  - MAC Users: Open the file titled "MAC\_USERS\_START\_HERE.pdf"

- The CD-ROM is presented in Adobe Acrobat and we included Adobe Reader software on the CD to ensure that all users can access the CD-ROM, whether they have Adobe installed on their computer or not. If, however, the CD menu is not opening for you, try launching the Adobe Reader manually. The Adobe Reader software is located in the folder titled "Acrobat\_Reader." Open the file titled "AdbeRdr811\_en\_US.exe" and the Adobe Reader software will download. You should then be able to launch the CD. You can also download Adobe Reader from free from the Adobe Website, <http://www.adobe.com>.
- If you have questions about using the CD-ROM, or do not have a CD drive, please contact Customer Service.

## INFLUENZA PANDEMIC EMERGENCY: THE MEDICARE PROGRAM PREPARES

~ Revised CMS Special Edition MLN Matters ~

~Part A & Part B~

MLN Matters Number: SE0836 **Revised**  
Related CR Release Date: N/A  
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A  
Effective Date: N/A  
Implementation Date: N/A

**Note:** This article was revised on November 6, 2008, to include a link to recently-issued CR 6146 and to update the link to CR6174, which was recently revised by CMS. All other information remains the same.

### Provider Types Affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), carriers or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

### Impact on Providers

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

### Background

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

Decision to implement would occur if:

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

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

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

### Dedicated CMS Web Page Now Available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at [http://www.cms.hhs.gov/Emergency/10\\_PandemicFlu.asp](http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp) on the CMS Website. That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

### Additional Information

Additional CMS influenza pandemic policy documents include:

- CR 6146, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R386OTN.pdf> on the CMS Website;
- CR 6164, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R379OTN.pdf> on the CMS Website; and
- CR 6174, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R396OTN.pdf> on the CMS Website.

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

## INFLUENZA VACCINE AND THE PNEUMOCOCCAL VACCINE PAYMENT ALLOWANCES BASED ON 95 PERCENT OF THE AVERAGE WHOLESALE PRICE (AWP)

~ Revised CMS MLN Matters ~

~ Part A & Part B ~

MLN Matters Number: MM6153 **Revised**  
Related CR Release Date: October 31, 2008  
Related CR Transmittal #: R1623CP

Related Change Request (CR) #: 6153  
Effective Date: September 1, 2008  
Implementation Date: No later than  
December 1, 2008

**Note:** This article was revised on November 7, 2008, to reflect the correct payment amount for CPT code 90669. The correct amount is \$78.803. All other information remains the same.

### Provider Types Affected

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

**Provider Action Needed**

This article is based on Change Request (CR) 6153 which provides the updated payment allowances, effective as of September 1, 2008, for influenza and pneumococcal vaccines when payment is based on 95 percent of the average wholesale price (AWP).

**Background**

The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year. The payment allowances for pneumococcal vaccines are updated on a quarterly basis. Change Request (CR) 6153 provides the payment allowances for the following influenza virus vaccines: Current Procedural Terminology (CPT) codes 90655, 90656, 90657, 90658, and 90660 as well as the pneumococcal vaccines (CPT codes 90732 and 90669) when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2008, these Medicare Part B payment allowances for influenza vaccines are as follows:

CPT Code	Allowance
90655	\$16.879
90656	\$18.198
90657	\$6.609
90658	\$13.218

CPT 90660 (FluMist, a nasal influenza vaccine) may be covered if the local Medicare claims processing contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for CPT 90660 is \$22.316 (effective September 1, 2008).

The Medicare Part B payment allowance for the pneumococcal vaccine CPT code 90732 is \$32.703, and for CPT code 90669 is \$78.803. These payment allowances were published as a part of the July 2008 Quarterly Average Sales Price (ASP) Drug Pricing Files, as specified in CR6049. See <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6049.pdf> on the CMS Website to view the article related to CR 6049.

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

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

Medicare Contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR6153. However, they will adjust such claims that you bring to their attention.

**Additional Information**

The official instruction, CR 6153, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1623CP.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.

**MAC J5 FISS REGION MERGE****~Part A~**

Effective February 3, 2009, Wisconsin Physicians Service (WPS) will be merging the four existing MAC J5 Fiscal Intermediary Standard System (FISS) regions for Iowa, Kansas, Nebraska, and Missouri into one MAC J5 FISS region. On February 2, 2009, there will be a dark day for system verification to ensure that the region is populated properly and running appropriately. During this dark day, the FISS system will not be available to the providers. Providers may continue to submit Electronic Media Claims (EMC) as they currently do; however, any claims submitted on the dark day, February 2, 2009, will be held until February 3, 2009. There will be no Electronic Data Interchange (EDI) reports or Electronic Remittance Advice (ERA) files generated for February 2, 2009.

**How the MAC J5 FISS Region merge will affect EMC submitters and Direct Data Entry (DDE) users:***EMC*

- Currently EMC submitters receive an accept/reject report for each individual state for which they submit claims. When the MAC J5 FISS Region merge occurs, providers will receive one accept/reject report for all claims submitted electronically, regardless of the state.
- Providers will continue to submit EMC claims as they currently do today.
- If you have questions, please contact the EDI hotline at 1-866-503-9670.

*DDE*

- Currently, Direct Data Entry (DDE) users choose from one of four MAC J5 FISS regions. When the MAC J5 FISS Region merge occurs, DDE users will access all states by selecting the MAC J5 FISS PROD option from the product selection menu.
- If you have any questions, please contact the DDE Systems department at 1-866-518-3295.

## UPDATE TO MEDICARE DEDUCTIBLE, COINSURANCE, AND PREMIUM RATES FOR 2009

~ Revised CMS MLN Matters ~

~ Part A & Part B ~

MLN Matters Number: MM6258 **Revised**  
 Related CR Release Date: November 17, 2008  
 Related CR Transmittal #: R56GI

Related Change Request (CR) #: 6258  
 Effective Date: January 1, 2009  
 Implementation Date: January 5, 2009

**Note:** This article was revised on November 18, 2008, to reflect changes made to CR6258, which was re-issued on November 17. The CR transmittal number and release date (see above) were revised and the Web address for accessing CR6258 was changed. All other information remains the same.

### Provider Types Affected

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

### Impact on Providers

This article is based on Change Request (CR) 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

#### **2009 Part A - Hospital Insurance (HI)**

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

*Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.*

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during an illness episode. The 2009 deductible and coinsurance amounts are in the following table.

**Table 1**

2009 Part A – Hospital Insurance (HI)			
<b>Deductible</b>	<b>\$1,068.00</b>		
<b>Coinsurance</b>	<b>Hospital</b>		<b>Skilled Nursing Facility</b>
	<b>Days 61-90</b>	<b>Days 91-150 (Lifetime Reserve Days)</b>	<b>Days 21-100</b>
	\$267.00	\$534.00	\$133.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2009 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	\$443.00 per month
Base Premium with 10% Surcharge	\$487.30 per month
Base premium with 45% Reduction	\$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	\$268.40 per month

#### **2009 Part B - Supplementary Medical Insurance (SMI)**

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

**For 2009, the standard premium for SMI services is \$96.40 a month; the deductible is \$135.00 a year; and the coinsurance is 20%.** The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6258, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R56GI.pdf> on the CMS Website.

#### **Additional Information**

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

**Claim Submission****2009 ANNUAL UPDATE TO THE THERAPY CODE LIST**

~CMS MLN Matters~

~Part A &amp; Part B~

MLN Matters Number: MM6254  
Related CR Release Date: October 31, 2008  
Related CR Transmittal #: R1625CP

Related Change Request (CR) #: 6254  
Effective Date: January 1, 2009  
Implementation Date: January 5, 2009

**Provider Types Affected**

Physicians, therapists, and providers of therapy services billing Medicare Carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for outpatient rehabilitation therapy services.

**What Providers Need to Know**

This article is based on Change Request (CR) 6254 and alerts providers to updates to Medicare's therapy code list with two "sometimes" therapy codes for CY 2009. Note that these codes always represent therapy services and require the use of a therapy modifier when performed by therapists. The two codes added are:

1. **95992** – Standard Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day.
2. **0183T** – Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.

**Note:** If billed by a hospital subject to Outpatient Prospective Payment System (OPPS) for an outpatient service, CPT code 0183T will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. In addition, no Medicare Physician Fee Schedule (MPFS) amount exists for this code. Since the local carrier (or A/B MAC) determines the coverage and pricing for this code, the FI or A/B MAC contacts the local contractor to obtain the appropriate fee schedule amount.

**Background**

This instruction updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2008 and 2009 HCPCS/CPT-4.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Chapter 5 which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website and the *Medicare Benefit Policy Manual*, Chapter 12, which is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c12.pdf> on the CMS Website.

**Additional Information**

The official instruction (CR6254) issued to your Medicare FI, A/B MAC, carrier or RHHI, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1625CP.pdf> on the CMS Website.

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

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

## **ANNUAL UPDATE OF HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT**

~CMS MLN Matters~

~Part A & Part B~

**MLN Matters Number: MM6262**

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

**Related CR Transmittal #: R1633CP**

**Related Change Request (CR) #: 6262**

**Effective Date: January 1, 2009**

**Implementation Date: January 5, 2009**

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

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

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

**CAUTION – What You Need to Know**

This article is based on Change Request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

**GO – What You Need to Do**

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

**Background**

The Social Security Act (Section 1842(b)(6)); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see [http://edocket.access.gpo.gov/cfr\\_2005/octqtr/42cfr409.100.htm](http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm) on the Internet and in

the Medicare Claims Processing Manual (Chapter 10, Section 20.1), available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., 'K' codes) throughout the calendar year.

**The following HCPCS code is added** to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
<b>A6545</b>	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

**The following HCPCS code is deleted** from the home health consolidated billing supply code list, and this code is being removed because it is non-covered by Medicare statute.

Deleted HCPCS Code	Descriptor
<b>A6413</b>	Adhesive Bandage, First-Aid Type, any size, each

#### Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf> on the CMS Website.

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

## ARCHIVING AND RETRIEVING OF THE INTEGRATED OUTPATIENT CODE EDITOR (IOCE) AND THE MEDICARE CODE EDITOR (MCE) FOR PROCESSING CLAIMS

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6177  
 Related CR Release Date: October 24, 2008  
 Related CR Transmittal #: R391OTN

Related Change Request (CR) #: 6177  
 Effective Date: April 1, 2009  
 Implementation Date: April 6, 2009

#### Provider Types Affected

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

#### Provider Action Needed

This article is based on Change Request (CR) 6177 and assures providers that Medicare contractors will have the ability to process claims and apply edits correctly. The Centers for Medicare & Medicaid Services (CMS) requires Medicare contractors to establish a

mechanism to retrieve OCE versions, effective for a date of service (DOS) prior to the most recent iteration (minus seven years), and establish a mechanism to retrieve MCE versions effective for discharges prior to the most recent iteration (minus ten years).

**Background**

Currently the Fiscal Intermediary Standard (or Shared) System (FISS) includes one copy of the IOCE software, which is supplied by 3M and replaced each quarter. However, to maintain a reasonable size for the software, there is a need to archive versions of the OCE greater than seven years (28 versions) within the Shared System so contractors can have the capability to process claims with dates of service prior to the single copy FISS currently maintains. For instance, if a contractor is required to process an OPPS claim on June 1, 2009, and the claim has a DOS of April 2, 2002, the contractor should be able to process the claim without special handling. However, if the OPPS claim had a DOS of March 30, 2002, the contractor must have the capacity to retrieve the archived January 2002 version of the OCE to correctly process the claim.

This is also true for the MCE. There is a complete replacement product each year which includes all versions. Because it is not possible to use the same archiving and calling conventions used for the inpatient PRICERS, CR6177 directs Medicare contractors to develop a new archiving and call process for FISS to use in accessing archived OCEs and MCEs.

CR6177 instructs FIs, A/B MACs and RHHIs to be able to:

- Process claims, with DOS prior to the most recent 28 versions of the OCE, with the appropriate corresponding archived version; and
- Process claims, with discharges prior to the most recent iteration of the MCE, with the appropriate corresponding archived version.

**Additional Information**

The official instruction (CR6177) issued to your Medicare A/B MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/transmittals/downloads/R391OTN.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.

## DISCARDED ERYTHROPOIETIN STIMULATING AGENTS (ESAS) FOR METHOD I HOME DIALYSIS

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6133  
Related CR Release Date: August 29, 2008  
Related CR Transmittal #: R1581CP

Related Change Request (CR) #: 6133  
Effective Date: December 1, 2008  
Implementation Date: December 1, 2008

### Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ESA services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on Change Request (CR) 6133, which updates the Medicare Claims Processing Manual (Publication 100-04), Chapters 8 (Sections 60.4.4.1 (Self Administered EPO Supply) and 60.7.4 (Darbepoetin Alfa (Aranesp) Furnished to Home Patients)) and Chapter 17 (Section 40.1 (Discarded Erythropoietin Stimulating Agents for Home Dialysis)) for discarded drugs and biologicals and CR 6133 includes specific instructions regarding appropriately discarded self-administered erythropoietin stimulating agents for Method I home dialysis patients. Be sure billing staff is aware of these changes.

### Background

Supplies of Erythropoietin Stimulating Agents (ESAs) for self administration are billed according to the pre-determined plan of care schedule provided to home dialysis patients that meet the criteria for self administered ESAs as discussed in the Medicare Claims Processing Manual (Chapter 8, Sections 60.4 and 60.7. (See revised Chapter 8, Sections 60.4.4.1 and 60.7.4 which are Attachments of CR 6133.) The renal facility, through the amounts prescribed in the plan of care, shall ensure the patient's ESAs on hand at any time does not exceed a 2-month supply. The Centers for Medicare & Medicaid Services (CMS) expects the facility to minimize excess dispensing of the ESAs for self administration based on the patient's plan of care.

Multiuse vials are generally not subject to payment for discarded amounts of drugs or biologicals. **An exception is applied specifically to self administered erythropoietin stimulating agents (ESAs) by Method I home dialysis patients.**

Providers may bill the Medicare program using the modifier 'JW' for the amount of ESAs appropriately discarded, if the home dialysis patient must discard a portion of the ESA supply due to:

- Expiration of a vial because of interruption in the patient's plan of care, or
- Unused ESAs on hand after a patient's death.

Note: In these situations, the maximum numbers of administrations generally allowed per month (i.e., 13 to 14 administrations) **are not expected to all be administered to a patient.**

This applies only to home dialysis patients who meet the Method I conditions described in the Medicare Benefits Policy Manual (Chapter 11, Section 90 (Epoetin (EPO)), and does not apply to Method II home dialysis patients. See <http://www.cms.hhs.gov/manuals/Downloads/bp102c11.pdf> on the CMS Website.

When billing for discarded ESAs for Method 1 patients in accordance with the policy in the Medicare Claims Processing Manual (Chapter 17, Section 40.1; see to CR 6133), the provider must show the amount discarded on a separate line item with the modifier 'JW', and the line item date of service should be:

- The date of the last covered administration according to the plan of care, or
- The date of death, if the patient dies.

#### Additional Information

The official instruction, CR 6133, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1581CP.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.

## LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR OCTOBER 2008

~ Revised CMS MLN Matters ~

~ Part A & Part B ~

MLN Matters Number: MM6213 **Revised**  
Related CR Release Date: October 2, 2008  
Related CR Transmittal #: R1606CP

Related Change Request (CR) #: 6213  
Effective Date: October 1, 2008  
Implementation Date: October 6, 2008

**Note:** This article was revised on October 21, 2008, to correct the reference to the NCD from 190.18 to 190.19 on the bottom of page 3. A code for Gamma Glutamyl Transferase was corrected to 571.42 on page 5. It also corrected two codes on page 6 for FOBT, by adding a zero to correct the ICD-9-CM codes to 209.40 and 209.50. All other information remains the same.

#### Provider Types Affected

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

#### What You Need to Know

This article is based on Change Request (CR) 6213, which announces the changes that will be included in the October 2008 release of the edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in July 2008. CR 6213 incorporates all changes from July 2008 to the present.

**Background**

The National Coverage Determination (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* (Publication 100-04), 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.

CR 6213 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for October 2008 as described below. These changes become effective for services furnished on or after October 1, 2008.

**For Bacterial Urine Culture:**

- Add ICD-9-CM codes 038.12, 599.70, 599.71, 599.72, 780.60, 780.61, 780.62, 780.63, 780.64, 780.65, 788.91, and 788.99 to the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.
- Delete ICD-9-CM codes 599.7, 780.6, and 788.9 from the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Urine Culture, Bacterial (190.12) NCD.

**For HIV Testing:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the HIV Testing (Prognosis Including Monitoring (190.13)) NCD.
- Add ICD-9-CM codes 078.12, 136.21, 136.29, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.
- Delete ICD-9-CM codes 136.2 and 780.6 from the list of ICD-9-CM codes covered by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.

**For Blood Counts:**

- Add ICD-9-CM codes 078.12, V45.11, V45.12, V49.83, V51.0, V51.8, V61.01, V61.02, V61.03, V61.04, V61.05, V61.06, V61.09, V62.21, V62.22, V62.29, and V72.42 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 V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Blood Counts (190.15) NCD.
- Delete ICD-9-CM codes V45.1, V51, V61.0, and V62.2 from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.

**For Partial Thromboplastin Time (PTT):**

- Add ICD-9-CM codes 275.5, 238.77, 571.42, 599.70, 599.71, 599.72, and 611.89 to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes 599.7 and 611.8 from the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.

**For Prothrombin Time (PT):**

- Add ICD-9-CM codes 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 511.81, 511.89, 571.42, 599.70, 599.71, 599.72, 611.89, and 999.89 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Delete ICD-9-CM codes 511.8, 599.7, 611.8, and 999.8 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Prothrombin Time (PT) (190.17) NCD.

**For Serum Iron Studies:**

- Add ICD-9-CM codes 199.2, 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.60, 209.61, 209.62, 209.63, 209.64, 209.65, 209.66, 209.67, 209.69, 209.30, 238.77, 571.42, 999.89, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM codes 999.8 and V15.2 from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Serum Iron Studies (190.18) NCD.

**For Collagen Crosslinks:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Collagen Crosslinks, Any Method (190.19) NCD.

**For Blood Glucose Testing:**

- Add ICD-9-CM codes 038.12, 707.20, 707.21, 707.22, 707.23, 707.24, 707.25, 780.72, V23.85, and V23.86 to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Blood Glucose Testing (190.20) NCD.

**For Glycated Hemoglobin/Glycated Protein:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

**For Thyroid Testing:**

- Add ICD-9-CM codes 275.5, 780.72, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM code 780.6 from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Thyroid Testing (190.22) NCD.

**For Lipid Testing:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Lipids Testing (190.23) NCD.

**For Digoxin Therapeutic Drug Assay:**

- Add ICD-9-CM codes 275.5, 339.3, and 780.72 to the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.

**For Alpha-Fetoprotein:**

- Add ICD-9-CM codes 571.42, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Alpha-Fetoprotein (190.25) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Alpha-Fetoprotein (190.25) NCD.

**For Carcinoembryonic Antigen:**

- Add ICD-9-CM codes 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Carcinoembryonic Antigen (190.26) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Carcinoembryonic Antigen (190.26) NCD.

**For Human Chorionic Gonadotropin:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.

**For Tumor Antigen by Immunoassay-CA125:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Tumor Antigen by Immunoassay-CA125 (190.28) NCD.

**For Tumor Antigen by Immunoassay-CA15-3/CA27.29:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Tumor Antigen by Immunoassay-CA15-3/CA27.29 (190.29) NCD.

**For Tumor Antigen by Immunoassay-CA19-9:**

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Tumor Antigen by Immunoassay-CA19-9 (190.30) NCD.

**For Prostate Specific Antigen (PSA):**

- Add ICD-9-CM codes 599.70, 599.71, and 599.72 to the list of ICD-9-CM codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM code 599.7 from the list of codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the (PSA) (190.31) NCD.

**For Gamma Glutamyl Transferase:**

- Add ICD-9-CM codes 275.5, 038.12, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 558.41, 558.42, and 571.42 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

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

- Add ICD-9-CM code 780.72 to the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

**For Fecal Occult Blood Test (FOBT):**

- Add ICD-9-CM codes 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 530.13, 558.41, 558.42, 569.44, 571.42, and 780.72 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34 ) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the FOBT (190.34) NCD.

**For All 23 NCDs (190.12-190.34):**

- Add ICD-9-CM codes V28.81, V28.82, V28.89, V68.01, and V68.09 to the list of denied ICD-9-CM codes for all 23 Lab NCDs.

**Additional Information**

The official instruction, CR 6213, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1606CP.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.

**REPORTING NATIONAL PROVIDER IDENTIFIERS (NPI) ON  
CLAIMS FOR OUT-OF-JURISDICTION PURCHASED  
MAMMOGRAPHY PREVENTIVE SCREENING AND DIAGNOSTIC  
SERVICES**

~CMS MLN Matters~

~Part B~

MLN Matters Number: MM6237

Related CR Release Date: October 31, 2008

Related CR Transmittal #: R1624CP

Related Change Request (CR) #: 6237

Effective Date: December 1, 2008

Implementation Date: December 1, 2008

**Provider Types Affected**

Physicians and other Part B providers/suppliers who submit bills to Medicare carriers and Medicare Administrative Contractors (A/B MAC) for mammography services provided to Medicare beneficiaries.

**What You Need to Know**

CR 6237, from which this article is taken, provides billing instructions for using the NPI on paper, or electronically-submitted, Medicare claims for purchased mammography screening and diagnostic services when the service is performed **outside** of the carrier's or A/B MAC's claims processing jurisdiction. In this situation, billing providers should report their own NPI as the performing provider and also provide the name, address, and zip code of the performing physician/supplier.

**You should be aware that carriers and AB MACs will return your out-of-jurisdiction, purchased mammography screening or diagnostic service claims as unprocessable if you submit them without the billing provider's NPI; and the name, address, and ZIP code of the performing physician/supplier.**

**Additional Information**

You can find more information about the reporting of the NPI on claims for out-of-jurisdiction purchased mammography preventive screening and diagnostic services by going to CR 6237, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1624CP.pdf> on the Centers for Medicare & Medicaid (CMS) Website.

For claims processing instructions on the CMS-1500 form and electronic form *ANSI X12 837P* you can refer to the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 10.1.1.1. (Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004). That manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Website. To learn more about the NPI in general, visit <http://www.cms.hhs.gov/NationalProidentStand> on the CMS Website.

If you have any questions, please contact your carrier 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.

## REVISION TO THE REPORTING REQUIREMENTS OF QUALIFYING HOSPITAL STAYS ON INPATIENT SKILLED NURSING FACILITY (SNF) AND SWING BED (SB) CLAIMS

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6233

Related CR Release Date: October 24, 2008

Related CR Transmittal #: R1618CP

Related Change Request (CR) #: 6233

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

### Provider Types Affected

Skilled Nursing Facilities (SNFs) and Swing Bed Facilities (SBs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on Change Request (CR) 6233 which updates the requirement for reporting prior qualifying hospital stay dates on inpatient SNF and SB claims. Be sure billing staff are aware of these requirements.

### Background

SNF and SB providers must submit a qualifying hospital stay, or an appropriate condition code for bypassing the qualifying stay, if applicable, **on all claims**, including initial and subsequent claims that are submitted as covered. This is applicable for submitted bill types 21x (SNF inpatient) and 18x (Swing Bed inpatient). This also includes all covered claims, including claims submitted for benefits exhaust denials.

Covered claims submitted on 21x and 18x bill types that do not contain a qualifying hospital stay (using occurrence span code 70 with the qualifying hospital stay dates) or an appropriate condition code indicating why a qualifying hospital stay is not applicable will be denied.

### Additional Information

The official instruction, CR 6233, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1618CP.pdf> on the Centers for Medicare & Medicaid Services (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.

**Coverage – General****CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY  
FOR OBSTRUCTIVE SLEEP APNEA (OSA)**

~ Revised CMS MLN Matters ~

~ Part A &amp; Part B ~

MLN Matters Number: MM6048 **Revised**  
Related CR Release Date: October 15, 2008  
Related CR Transmittal #: R96NCD

Related Change Request (CR) #: 6048  
Effective Date: March 13, 2008  
Implementation Date: August 4, 2008

**Note:** This article was revised on October 16, 2008, to reflect changes to CR 6048, which CMS revised on October 15, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. In addition, some language in item 3, on page 3 was clarified. All other information remains the same.

**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 Disturbance Index (RDI) are met:
  - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
  - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

As previously stated, the AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring. However, there is variability in the published medical literature about the definition of the events that constitute a respiratory disturbance. The technology assessment that supported this NCD recognized this variability and defined RDI in the context of the specific sleep test technology under review. For the purposes of this NCD, a respiratory disturbance is defined in the context of the sleep test technology of interest and does not require direct measurement of airflow. Local contractors will, as needed, determine, based on their review of the published, peer-reviewed medical literature, the equivalent test result criteria corresponding to the required AHI or RDI for Type IV devices measuring 3 or more channels that do not measure AHI or RDI directly.

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/R96NCD.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.

## NEW HEMOPHILIA CLOTTING FACTOR AND HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODE AND TERMINATED HEMOPHILIA CLOTTING FACTOR HCPCS CODE

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6268  
Related CR Release Date: October 24, 2008  
Related CR Transmittal #: R394OTN

Related Change Request (CR) #: 6268  
Effective Date: January 1, 2009  
Implementation Date: April 6, 2009

### Provider Types Affected

Hospital providers submitting claims to Medicare Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs) for inpatient services provided to Medicare beneficiaries

### Provider Action Needed

This article is based on Change Request (CR) 6268 which announces that, effective for inpatient claims with dates of discharge on or after January 1, 2009, Healthcare Common Procedure Coding System (HCPCS) code J7186 **will be payable** by Medicare. HCPCS code Q4096 **will not be payable** by Medicare for claims with dates of discharge on or after January 1, 2009.

### Background

Change Request (CR) 6268 instructs that Healthcare Common Procedure Coding System (HCPCS) code J7186 will be payable by Medicare for inpatient claims with dates of discharge on or after January 1, 2009, and HCPCS code Q4096 will not be payable by Medicare for claims with dates of services after January 1, 2009.

See CR 6006, transmittal 1564, dated July 25, 2008, titled, "New Hemophilia Clotting Factor and HCPCS Code", at <http://www.cms.hhs.gov/Transmittals/downloads/R1564CP.pdf> on the Center for Medicare & Medicaid Services (CMS) Website for more information, regarding payment for Q4096, prior to January 1, 2009. An MLN Matters article related to that transmittal is also available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6006.pdf> on the CMS Website.

Effective for inpatient claims with dates of discharge on or after January 1, 2009, **the following HCPCS code will be payable** by Medicare:

HCPCS	Short Descriptor	Long Description	Effective Dates
J7186	Antihemophilic VIII/VWF comp	INJECTION, ANTIHEMOPHILIC FACTOR VIII/VON WILLEBRAND FACTOR COMPLEX,(HUMAN), PER FACTOR VIII I.U.	January 1, 2009

Effective for inpatient claims with dates of discharge on or after January 1, 2009, the following HCPCS code will no longer be payable by Medicare:

HCPCS	Short Descriptor	Long Description	Effective Dates
Q4096	VWF complex, not Humate-P (NOS)	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO VWF complex, NOS	April 1, 2008 (Terminated effective January 1, 2009)

Appropriate systems changes for editing J7186 and Q4096 on inpatient claims will be made by the Fiscal Intermediary Standard System (FISS) and the Common Working File (CWF) in the April 2009 release.

**During the period between January 1, 2009, and April 5, 2009** (date of the FISS and CWF implementation of the hemophilia inpatient edit changes in the April 2009 release), CR 6268 instructs that the following procedures are to be followed for inpatient claims:

1. Providers will submit claims for hospital inpatient care, omitting J7186. This includes the following hospitals:
  - Hospitals paid under the inpatient prospective payment system (IPPS);
  - Hospitals paid under the long term care hospital prospective payment system (LTCH PPS);
  - Hospitals paid under the inpatient rehabilitation facility prospective payment system (IRF PPS); and
  - Hospitals paid on the basis of reasonable cost (TEFRA hospitals, critical access hospitals (CAHs), and
  - Indian Health Service (IHS) hospital inpatient services (actually paid on a DRG basis)] omitting J7186.

This **does not apply** to claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS. IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis on the claim. IPFs should refrain from including J7186 on their inpatient claims.

2. Once the provider has received PPS payment for the inpatient claim, the provider will immediately submit an adjustment request (Type of Bill (TOB) = 117), this time including J7186.
3. Medicare contractors will hook and hold any provider initiated adjustment requests containing J7186 with discharge dates between January 1, 2009, and April 5, 2009.
4. Medicare contractors will return to provider (RTP) any initial inpatient claims (TOB 11x) containing J7186 with discharge dates on or after January 1, 2009 but prior to April 1, 2009.
5. Once FISS and CWF have been updated for the clotting factor edits to include J7186, Medicare contractors will release all held adjustment requests.

**Note:** There is no impact on outpatient hospital claims or on any Skilled Nursing Facility (SNF) claims as payment is made under different methodologies. J7186 is payable in those settings effective January 1, 2009.

### Implementation

The implementation date is April 6, 2009.

### Additional Information

The official instruction, CR 6268, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R394OTN.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.

## MIST THERAPY™ SYSTEM 5.0 WOUND TREATMENT DEVICE

### ~Part B~

The MIST Therapy™ System is a wound care product designed to impact key areas of the wound repair process. Multiple providers have asked WPS Medicare if this service is covered using Current Procedural Terminology (CPT) code 0183T. The following is in response to these inquiries:

Ultrasonic Wound Debridement (CPT code 0183T) is a system that uses continuous low frequency ultrasonic energy to atomize a liquid and deliver continuous low frequency ultrasound to the wound bed. Medicare does not consider this cleansing method to be a significantly separately payable coverable service. Therefore, Mist Therapy™ (CPT code 0183T) is included in the payment for the Evaluation and Management (E/M) or wound care services.

## OPEN LOCAL COVERAGE DETERMINATIONS MEETING

### ~Part A & Part B~

Wisconsin Physicians Service (WPS), the Medicare Administrative Contractor (MAC) for Iowa, Kansas, Missouri, and Nebraska, will hold an open Local Coverage Determinations (LCD) meeting for persons wishing to provide input concerning LCDs that are currently in the development process.

The next Open Policy Meeting will be held Wednesday, December 17, 2008, at 1:00 p.m. CT, 2:00 p.m. ET.

WPS will hold the open meeting to allow the submission of scientific evidence and other information from members of the general public relating to draft policies.

Details on the meeting are on the WPS Medicare Website:  
<http://www.wpsmedicare.com/mac/policy/partbopenmtg.shtml>

## TEMPORARY PROSTATIC URETHRAL STENT

~Part A & Part B~

WPS Medicare will cover the insertion of a temporary prostatic urethral stent when used for up to a 30 day temporary use to maintain urine flow and allow voluntary urination in men following minimally invasive treatment for benign prostatic hypertrophy and after initial post-treatment catheterization. The medical record must document these requirements.

Claims for this insertion should bill **CPT code 0084T**, Insertion of a temporary prostatic urethral stent. Only FDA approved stents (e.g. Spanner™) should be used. Place the name of the FDA-approved stent in item 19 of the CMS-1500 claim form or its electronic equivalent. Claims must also have the ICD-9 code for urethral obstruction 599.60. By definition, since this is a temporary stent, payment for 0084T also includes payment for the removal of the stent. Coverage for this procedure is effective 12/01/2008.

## UPDATE TO THE INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE) BENEFIT

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6223

Related CR Release Date: October 24, 2008

Related CR Transmittal #: R1615CP

Related Change Request (CR) #: 6223

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

### Provider Types Affected

Physicians and providers who submit claims to Medicare Fiscal Intermediaries (FIs), Carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for the IPPE provided to Medicare beneficiaries

### What You Need to Know

This article is based on Change Request (CR) 6223, which announces that, effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is expanding coverage for the IPPE benefit.

This expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, no later than 12 months (rather than 6 months as previously required) after the date the individual's first coverage period begins under Medicare Part B. However, this expanded coverage only applies if the IPPE is performed on or after January 1, 2009.

The IPPE has been expanded to include measurement of an individual's body mass index, and end-of-life planning as mandatory services (upon an individual's consent). The screening electrocardiogram (EKG) is no longer a mandatory part of the IPPE, but it may be performed as an optional one-time service as a result of a referral arising out of the IPPE. Be sure your billing staff is aware of these changes.

### Background

Pursuant to Section 101 (b) of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), CMS is amending section 410.16 and related regulation provisions of the

Code of Federal Regulations. Effective January 1, 2009, this expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, also known as the “Welcome to Medicare Visit”, not later than 12 months after the date the individual’s first coverage period begins under Medicare Part B.

## Changes to IPPE

### The Initial Preventive Physical Examination

- Effective for services performed on or after January 1, 2009, MIPPA changes the IPPE as follows:
  - Waives the deductible for the IPPE.
  - Adds the measurement of body mass index as part of the IPPE,
  - Adds end-of-life planning to the IPPE (upon an individual’s consent), and
  - Removes the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time screening service as a result of a referral arising out of the IPPE.

### Eligibility

- Effective January 1, 2009, the MIPPA of 2008 extends the eligibility period from 6 months after Part B enrollment to 12 months after enrollment.
- Effective for IPPEs performed on or after January 1, 2009, a beneficiary is eligible for the extended IPPE benefits of MIPPA when he/she first enrolls in Medicare Part B and receives the IPPE benefit within the first 12 months of the effective date of the initial Part B coverage period.
- For IPPEs performed on or after January 1, 2009, the Medicare deductible does not apply to the IPPE.
- The waived deductible is applicable to the IPPE (code G0402) only, but the coinsurance still applies. Prior to January 1, 2009, the deductible was not waived.

## Billing Requirements

### Codes Used to Bill the IPPE

- Effective January 1, 2005, the physician or qualified non-physician practitioner will bill for IPPEs performed on or before December 31, 2008, using HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.
- Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.
- For an IPPE performed during the global period of surgery refer to Section 30.6.6, Chapter 12 of the Medicare Claims Processing Manual for reporting instructions at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS Website.

The following HCPCS codes have been developed for the IPPE benefit effective January 1, 2009:

HCPCS Code	Short Descriptor
<b>G0402:</b> Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	Initial Preventive Exam

HCPCS Code	Short Descriptor
<b>G0403:</b> Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	EKG for initial prevent exam
<b>G0404:</b> Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	EKG tracing for initial prev
<b>G0405:</b> Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	EKG interpret & report preve

#### Professional Claims Processed by Carriers/MACs

- The type of service (TOS) for each of the new codes is as follows:
  - G0402: TOS = 1
  - G0403: TOS = 5
  - G0404: TOS = 5
  - G0405: TOS = 5
- The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.
- The deductible is waived for code G0402 after January 1, 2009, but the coinsurance still applies.

#### Institutional Claims Processed by FIs/MACs

- FIs/MACs will pay for code G0402 for the IPPE and code G0404 for the screening EKG, tracing only when those services are submitted on a TOB 12X or 13X for hospitals subject to the outpatient prospective payment system (OPPS). Codes G0403 and G0405 are not payable under the OPPS. Hospitals not subject to OPPS will be paid under current methodologies.
- For inpatient or outpatient services in hospitals in Maryland, payment is made according to the State Cost Containment System.
- For services performed on a 12X, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.
- For services performed on a 13X, IHS hospitals, payment is made based on the all-inclusive rate (AIR).
- For services performed on an 85X, IHS critical access hospitals (CAHs), payment is made based on an all inclusive facility specific per visit rate. For other CAHs billing on the 85X, payment is based on reasonable cost.
- For services billed by Skilled Nursing Facilities (SNFs) on the 22X, payment for the technical component of the EKG is based on the MPFS.

**NOTE:** HCPC code G0405 is a professional component and is only allowable on 71x, 73x and 85x (**CAH Method II**) TOBs. In addition, G0404 is a Technical component HCPCS code that can only be submitted on 12x, 13x, 22x, OR 85x(Method I and II) TOBs.

**Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) Special Billing Instructions**

- Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.

**OPPS Hospital Billing**

- Hospitals subject to OPSS (TOBs 12X and 13X) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. **The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404.**

**Reporting a Medically Necessary Evaluation and Management (E/M) at Same IPPE Visit**

- When the physician or qualified NPP provides a medically necessary E/M service in the same visit as the IPPE, CPT codes 99201 – 99215 may be used depending on the clinical appropriateness of the circumstances. CPT modifier –25 will be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE code **reported (G0344 or G0402, whichever applies based on the date of service).**

**Documentation**

- Physicians and qualified NPPs are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. The guidelines may be reviewed at [http://www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp) on the CMS Website.

**Medicare Notices and Messages****Remittance Advice Remark Codes and Claim Adjustment Reason Codes**

- Your Medicare contractors will use the appropriate Remittance Advice Remark Code, i.e., N117 (This service is paid only once in a patient's lifetime) when denying additional claims for an IPPE and/or a screening EKG.
- Your Medicare contractors will use the appropriate Claim Adjustment Reason Code, i.e., 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for an IPPE and/or a screening EKG.

**Advance Beneficiary Notice (ABN) as Applied to the IPPE**

- Effective for beneficiaries whose IPPE is provided on January 1, 2005, through December 31, 2008, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed.
- Effective for IPPEs performed **on or after January 1, 2009**, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Social Security Act Section 1862(a)(1)(K),

Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.

**Medicare Summary Notices (MSNs)**

- When denying additional claims for G0402, Medicare contractors will use MSN message 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.
- When denying additional claims for screening EKG codes G0403, G0404 and G0405, contractors will use MSN message 20.12 - This service was denied because Medicare only covers this service once a lifetime.

**Additional Information**

The official instruction (CR6223) issued to Medicare Carriers, FIs and A/B MACs regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1615CP.pdf> on the CMS Website. If you have any questions, please contact your Medicare contractor (carrier, FI, or 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**

**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 on its Website:

[http://www.wpsmedicare.com/mac/policy/mac\\_lcds.shtml](http://www.wpsmedicare.com/mac/policy/mac_lcds.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.

<b>Part A</b>	
<b>Iowa Part A</b>	<b>Kansas Part A</b>
WPS Medicare Part A Freedom of Information P.O. Box 7665 Madison, WI 53707-7665	WPS Medicare Part A Freedom of Information P.O. Box 7576 Madison, WI 53707-7576
<b>Missouri Part A</b>	<b>Nebraska Part A</b>
WPS Medicare Part A Freedom of Information P.O. Box 8890 Madison, WI 53707-8890	WPS Medicare Part A Freedom of Information P.O. Box 8799 Madison, WI 53708-8799
<b>Part B</b>	
<b>Iowa</b>	<b>Kansas</b>
WPS Medicare Part B Freedom of Information P.O. Box 8550 Madison, WI 53708-8550	WPS Medicare Part B Freedom of Information P.O. Box 7238 Madison, WI 53707-7238
<b>Missouri (Western)</b>	<b>Missouri (Eastern)</b>
WPS Medicare Part B Freedom of Information P.O. Box 7128 Madison, WI 53707-7128	WPS Medicare Part B Freedom of Information P.O. Box 14260 Madison, WI 53708-0260
<b>Nebraska</b>	
WPS Medicare Part B Freedom of Information P.O. 8667 Madison, WI 53708	



## Revised Policies for December 2008

## ~Part B~

Part A/ Part B	Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
Part B	GSURG-537	<i>Application of Bioengineered Skin Substitutes and Skin Grafting</i>	LCD	Click here to view	34
Part B	OPHTH-520	<i>Complex Cataract Surgery</i>	LCD	Click here to view	34
Part B	RAD-039	<i>Stereotactic Body Radiation Therapy</i>	LCD	Click here to view	35
Part B	RAD-536	<i>Brachytherapy (non- coronary)</i>	LCD	Click here to view	36

**Coverage – Revised Policies****~Part B~****LCD Title**

Application of Bioengineered Skin Substitutes and Skin Grafting

**Contractor's Determination Number**

GSURG-537

**LCD Database ID Number**

L26650

Effective for claims submitted with dates of service on or after 10/01/2008, WPS will cover the new 2009 ICD-9-CM codes:

**For J7340:**

*249.60	Secondary diabetes mellitus with neurological manifestations; not stated as uncontrolled, or unspecified
*249.70	Secondary diabetes mellitus with peripheral circulatory disorders; not stated as uncontrolled, or unspecified

**For J7340:**

*249.60	Secondary diabetes mellitus with neurological manifestations; not stated as uncontrolled, or unspecified
*249.70	Secondary diabetes mellitus with peripheral circulatory disorders; not stated as uncontrolled, or unspecified

**~Part B~****Contractor's Policy Number**

OPHTH-520

**LCD Title**

Complex Cataract Surgery

**Primary Jurisdiction**

Iowa, Kansas, Missouri, Nebraska

**Revision Effective Date**

12/01/2008

**Documentation Requirements****CPT Code 66982**

WPS has determined that use of Epi-shugarcaine meets the complex cataract criteria (CPT code 66982) as described in the requirements listed below.

- Requirement for diagnoses: 366.00, 366.01, 366.02, 366.03, 366.04, 366.09, 366.10, 366.11, 366.13, 366.14, 366.16, 366.19, 366.23, 366.41, 366.44, 366.45, 366.46, 743.46; Indicate in the operative note the use of micro iris hooks inserted through four (4) separate corneal incisions, Beechler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, the intraocular lens implant was supported by using permanent intraocular sutures or a capsular support ring or an endocapsular ring was used to partially occlude the pupil, \*or Epi-shugarcaine was used to adequately dilate the pupil preoperatively.
- Requirement for diagnoses: 364.81, 364.82; Indicate in the operative note the use of micro iris hooks inserted through four (4) separate cornea incisions, Beechler or similar expansion device, multiple sphincterotomies created with scissors, sector iridotomy with suture repair of iris sphincter, permanent intraocular suture or a capsular support ring, or a ring used to partially occlude the pupil, or Epi-shugarcaine was used to adequately dilate the pupil preoperatively.



**~Part B~**

**Contractor's Determination Number**

RAD-039

**LCD Title**

Stereotactic Body Radiation Therapy

**CPT/HCPCS Codes**

(77373 and 77435 are used in free standing facilities only (i.e. clinic or ASC))

77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions

\*In the Hospital Outpatient Setting use the following codes

G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment



## ~Part B~

**LCD Title**

Brachytherapy (non-coronary)

**Contractor's Determination Number**

RAD-536

**CPT/HCPCS Codes**

Codes 77781, 77782, 77783 and 77784 will be discontinued as of 01/2008 and replaced by the following new codes 77785, 77786, 77787:

- \*77785 Remote afterloading high dose rate brachytherapy; 1 channel
- \*77786 Remote afterloading high dose rate brachytherapy; 2-12 channels
- \*77787 Remote afterloading high dose rate brachytherapy; Over 12 channels
- \*Q3001 Radioelements for brachytherapy, any type each (discontinued 12/30/2007 for ASC billing)

**\*Brachytherapy Sources Payable as of 01/01/2008 in the ASC setting**

A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie
C1716	Brachytherapy source, non-stranded, Gold-198, per source
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM
C2638	Brachytherapy source, stranded, Iodine-125, per source
C2639	Brachytherapy source, non-stranded, Iodine-125, per source
C2640	Brachytherapy source, stranded, Palladium-103, per source
C2641	Brachytherapy source, non-stranded, Palladium-103, per source
C2642	Brachytherapy source, stranded, Cesium-131, per source
C2643	Brachytherapy source, non-stranded, Cesium-131, per source
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source

**Coding Guidelines****\*19. \*Radioelements**

In all cases, the radioisotope must be billed by the provider licensed and trained in nuclear materials use. **The date of service for the radioelement claim must match the date of service for the procedure performed.**

- a. The expendable source Q3001 is only reimbursed when billed in an office or free-standing radiological facility (11), independent clinic (49).  
For electronic billing in item 19 narrative, list iodine (I-125); palladium (Pd-103); and cesium (Cs-131), the number of seeds ordered, invoice price and the number of

- seeds used in the procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss.
- b. In the OPPS setting use the source specific C code that best describes the radioelement should be used and it is priced off the OPPS fee schedule. 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.
  - c. In the ASC (24) setting, effective 01/01/2008, use the source specific C code that best describes the radioelement should be used. Prior to 01/01/2008 Code Q3001 was used in the ASC.

*Payment for Brachytherapy Sources in an ASC.*

*The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at hospitals' charges adjusted to costs. As a result of the legislative amendment, there is no prospective rate under the OPPS for that period. Therefore, contrary to the payment policy, payment indicators and payment rates included in previous guidance, including Addendum BB to the November 27, 2007 OPPS/ASC final rule, for dates of service July 1, 2008 through December 31, 2009, payment for brachytherapy sources will be made at contractor-priced amounts, consistent with payment policy for the revised ASC payment system when no OPPS prospective rate is available. CR-6205*

*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.*

For electronic billing in item 19 narrative, list iodine (I-125); palladium (Pd-103); and cesium (Cs-131), the number of seeds ordered, invoice price and the number of seeds used in the procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss.

***Until standard pricing can be established, the contractor will request by mail additional documentation (operative note and seed invoice) to confirm billed amount and number of seeds used.***

- d. In the hospital setting (21 or 22) the radioelement is covered by source specific C-codes. The code C1717 code should be billed for each fraction of HDR given (77781-4).

Radioelements inserted in the in-patient or outpatient setting should not be billed to Medicare Part B but to Part A under OPPS or Inpatient billing rules.

**\*20. Billing and Coding of Brachytherapy Performed in an Ambulatory Surgical Center (ASC)**

As of 01/01/2008 there are new CMS ASC billing instructions. Please refer to CMS payment rules for ASCs which can be found at:

<http://www.cms.hhs.gov/ASCPayment/>

The provision of brachytherapy services furnished to Medicare beneficiaries at an ASC is subject to applicable anti-kickback laws, regulations and policies. In addition, any use of radioactive material requires full compliance with Nuclear Regulatory Commission (NRC) guidelines.

**Electronic Data Interchange (EDI)****ELECTRONIC DATA INTERCHANGE (EDI) HOTLINE****~Part B~**

Providers and submitters who send their Medicare claims electronically occasionally need to contact the Medicare Part B EDI Hotline. In order to make your experience with the EDI Hotline more beneficial, here are a few tips you can use.

You should have your Submitter ID ready to give us either when we answer your call or when you leave a voicemail message. The Submitter Number has several names, including Submitter ID, Sender ID, User ID, or Billing Location Code. This number tells us how you are billing: whether through a clearinghouse or directly to us. If you bill directly to us, your submitter ID will be five (5) digits. The Submitter ID is the number you use to connect direct to the WPS Bulletin Board System or through a connectivity vendor to transmit.

The EDI Hotline will never ask you for your tax ID number. We do not have any system access using your tax ID number.

What we may ask for, however, is your NPI number. This is the number assigned to identify you as a provider by National Plan and Provider Enumeration System (NPPES). You will use this number for all Medicare Part B billing whether you send the claim electronically or on paper.

When you call, we will need your submitter ID, your NPI, and usually the date you submitted the file about which you are inquiring. If you have received a report indicating your claims have deleted, we will also ask you for the "Processed Date" of the report. This will enable us to look at the same report you are seeing so we can give you valid information.

Earlier in this article, we referenced your need to know whether you bill directly to Medicare or through a clearinghouse. If you bill directly to Medicare, your computer will dial in through a modem to our Bulletin Board System or a connectivity vendor. Your claims will only go to Medicare Part B, not through any other party. If you use a clearinghouse, your claims will send from your office to the clearinghouse, and then the clearinghouse will send your claims on to Medicare Part B. You might send all your electronic claims (Public Aid, Commercial insurances, Medicare, etc.) to the clearinghouse and they in turn will forward the Medicare claims to us and the other insurances to their proper parties. It is important to know the name of your clearinghouse for efficient response to your questions.

Sometimes the Medicare acronyms make it difficult for you to reach the right department at Medicare. One area in which we see particular problems is ERA/EFT. These two items, ERA and EFT, are distinctly different, and are not interchangeable. CMS strongly recommends all providers utilize ERAs and EFTs.

- The ERA is the Electronic Remittance Advice, and is your payment voucher in electronic format (also called your electronic Explanation of Medicare Benefits, or EOMB. It has nothing to do with actual issuing of checks or transfer of funds. The ERA tells you how Medicare applied your payment to each Medicare beneficiary. You can request ERA access or make changes to your ERA setup with the EDI Hotline.

- The EFT, or Electronic Funds Transfer, is the direct deposit of your Medicare payment into your bank. The Minnesota EDI staff (available at the numbers listed below) handles EFT.

You may never have problems with electronic billing, but if you do and you need to contact us, hopefully these tips will make your experience more pleasant. Our contact information is:

EDI Hotline: 866-503-9670

E-mail: [edimedicareb@wpsic.com](mailto:edimedicareb@wpsic.com)

For EFTs:

866-380-4742

952-885-2811

952-885-2881

952-885-2882

## **PC-ACE PRO32 BILLING SOFTWARE UPGRADE VERSION 1.96 NOW AVAILABLE ONLINE**

**~ Part B ~**

If you are currently using PC-Ace Pro32 billing software, you can now download the latest upgrade online at <http://www.wpsic.com/edi/pacepro32.shtml>.

Now available online is:

- The upgrade to the latest version of PC-Ace, version 1.96
- Instructions related to the upgrade
- Users Guides/Manuals

If you are not using the version listed above, it is very important that you update your software immediately.

It is important that each user updates their software program in a timely manner. As you receive software upgrades, please download/install the upgrades to update your program.

If you are NOT currently using this program but you are interested in using this HIPAA-compliant software, please contact our EDI Hotline at 866-503-9670 or download the PC-Ace request form from <http://www.wpsic.com/edi/pdf/medbpace.pdf>.

**General Information****COMPENDIA AS AUTHORITATIVE SOURCES FOR USE IN THE DETERMINATION OF A "MEDICALLY ACCEPTED INDICATION" OF DRUGS AND BIOLOGICALS USED OFF-LABEL IN AN ANTI-CANCER CHEMOTHERAPEUTIC REGIMEN****~CMS MLN Matters~****~Part A & Part B~**

MLN Matters Number: MM6191

Related CR Release Date: October 24, 2008

Related Change Request (CR) #: 6191

Effective Date: June 5, June 10, and July 2, 2008  
(see below)

Related CR Transmittal #: R96BP

Implementation Date: November 25, 2008

**Provider Types Affected**

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

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

This article is based on Change Request (CR) 6191 which updates the list of compendia recognized as authoritative sources of information for the determination of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens.

**CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) is recognizing the following as authoritative compendia and listing them in the Medicare Benefit Policy Manual (Chapter 15, Section 50.4.5) for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service-Drug Information (AHFS-DI), (existing)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (effective June 5, 2008)
- Thomson Micromedex DrugDex, (effective June 10, 2008) and
- Clinical Pharmacology (effective July 2, 2008).

**GO – What You Need to Do**

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

**Background**

In the past, the following three compendia were recognized as authoritative sources for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary of the Department of Health and Human Services determined that the use was not medically appropriate or the use was identified as not indicated in one or more such compendia):

1. American Medical Association Drug Evaluations (AMA-DE),
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

Because the AMA-DE and the USP-DI are no longer published (due to changes in the pharmaceutical reference industry), the AHFS-DI became the only remaining statutorily-named compendia available for the CMS to use as a reference. Consequently, CMS received requests from the stakeholder community for a process to revise the list of recognized authoritative compendia.

In the Medicare Physician Fee Schedule final rule for calendar year 2008, CMS established:

- A process for revising the list of compendia. (Section 1861(t)(2) of the Social Security Act; [[http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)], and
- A definition for “compendium.” (72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], 72 FR 66303-66306 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiapreamble.pdf>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

A compendium is defined “as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment.” (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>].

In addition, a compendium:

- (1) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; and,
- (2) Is indexed by drug or biological. (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>], 72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

During a public meeting on March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) generated a list of desirable characteristics to use when reviewing a compendium. Subsequently, the MedCAC advised CMS of their findings and recommendations regarding the desirable characteristics of compendia for use in the determination of medically-accepted indications of drugs and biologicals in anti-cancer therapy.

After CMS conducted a review of specific compendia and compared their characteristics with the MedCAC list of desirable characteristics, CMS determined the following are recognized as authoritative compendia and is listing them in the Medicare Benefit Policy Manual (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service - Drug Information (AHFS-DI),
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
- Thomson Micromedex DrugDex, and
- Clinical Pharmacology.

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as **medically accepted** if the:

- Indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use is **not medically accepted** by a compendium if the:

- Indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- Narrative text in AHFS or Clinical Pharmacology is “not supportive.”

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

Medicare contractors may also identify off-label uses that are supported by clinical research under the conditions identified in Section 50.4.5 of the Medicare Benefits Policy Manual, as amended by CR6191. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.

In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, Medicare contractors will evaluate the evidence in published, peer-reviewed medical literature listed in the revised Section 50.4.5.C, which is attached to CR6191. When evaluating this literature, Medicare contractors will consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- Whether the administered chemotherapy regimen is adequately represented in the published evidence.
- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- Whether the study is appropriate to address the clinical question.

#### **Additional Information**

The official instruction, CR 6191, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R96BP.pdf> on the CMS Website. The revised sections of the Medicare Benefit Policy Manual are attached to CR 6191.

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

## MEDICARE BENEFICIARIES IN STATE OR LOCAL CUSTODY

### ~Part A & Part B~

Effective April 1, 2003, Medicare denies claims for beneficiaries who are in the custody of a State or local government under the authority of a penal statute at the time the provider rendered the service. Using Social Security records showing health insurance claim (HIC) numbers and incarceration dates, Medicare identifies and rejects these claims.

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

### **Exclusion from Coverage**

Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

### **Claims Processing Procedures**

Providers and suppliers rendering services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of the **QJ modifier** *Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)*. This modifier indicates the state or local government agency requesting the healthcare items or services provided to the patient has notified the provider that the prisoner or patient is responsible to repay the cost of Medical services. Furthermore, the agency will pursue the collection of debts for furnishing such items and services with the same vigor and in the same manner as any other debt.

Carriers must deny claims identified by the Common Working File (CWF) as non-covered under 42 CFR 411.4(a) and 411.4(b) using Reason Code 96 *Non-covered charges*. The following Remark Code will also be used:

Remark Code	Message
N103	<i>Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt.</i>

### **Appeals**

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

**Program Safeguards****MEDICAL RECORDS REQUESTS****~Part A & Part B~**

Wisconsin Physicians Service (WPS) is authorized to access any records deemed necessary for the processing of Medicare claims. Furthermore, Medicare requires that the services are verifiable in order to be paid. WPS, as a Medicare contractor, has the responsibility of conducting random internal audits to verify services reported to the Medicare program against what is contained in the patient's medical record information.

When a provider receives a request for medical records from WPS, it is the responsibility of the provider to comply with the request within 45 business days from the date of the request. Failure to submit the requested records may result in the identification of a total overpayment for the services billed for the patient(s) in question. Additionally, further action could be taken to suspend all payments made to the billing provider from the Medicare program.

**Provider Education****DO YOU BILL PSYCHOTHERAPY SERVICES FOR PATIENTS IN A NURSING FACILITY?****~Part B~**

Federal legislation has set forth requirements for Skilled Nursing Facilities (SNF) to participate in the Medicare program, and for Nursing Facilities (NF) to participate in the Medicaid program. One requirement is that each SNF or NF resident have an initial and a periodic comprehensive assessment, in order to institute a comprehensive care plan that meets the residents medical, nursing, mental, and psychological needs. The care plan must be developed and revised by an interdisciplinary team that includes the attending physician and a registered nurse who has responsibility for the resident. The components of the care plan are documented on the physician's order sheet, which is signed by the physician and the nurse.

Please be aware that Medicare will not cover psychotherapy services that are performed for residents of a skilled nursing facility or nursing facility, unless one of the following criteria is met:

1. The resident's attending physician evaluates the resident and authorizes the order for the psychotherapy, or the referral of the resident to another provider specialty.  
or
2. A named physician, whose attendance is required by the resident or the residents interested family member, legal guardian, or power of attorney for health care, evaluates the resident and authorizes the order for the psychotherapy services. The attending physician must be notified of any change in the resident's physical, mental, or psychosocial status, or of the need to alter the resident's treatment significantly.

A "PRN" or standing order for psychotherapy is not acceptable.

To view additional information about Coverage of Services and Procedures in Nursing Facilities, refer to Local Coverage Determination (LCD) L26570. It is located at the following CMS Website address:

[http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd\\_id=26570&lcd\\_version=4&show=all](http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=26570&lcd_version=4&show=all)

**EDUCATION SCHEDULE****~Part A & Part B~**

Be sure to visit the WPS Medicare Education Schedule at <http://www.wpsmedicare.com/mac/education/schedule.shtml> to learn more about the educational events we have scheduled for the upcoming months.

Some of the educational events WPS Medicare is hosting include the following:

- Critical Access Hospital (CAH) Swing Bed Consolidated Billing Exception Ask-the-Contractor Teleconference (ACT) *(Part A)*
- Chiropractic Care Seminar *(Part B)*
- Evaluation and Management Seminar *(Part B)*

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

**Reimbursement****ANNOUNCEMENT OF MEDICARE RURAL HEALTH CLINICS (RHCS)  
AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS) PAYMENT  
RATE INCREASES**

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6218  
Related CR Release Date: October 31, 2008  
Related CR Transmittal #: R1626CP

Related Change Request (CR) #: 6218  
Effective Date: January 1, 2009  
Implementation Date: January 5, 2009

**Provider Types Affected**

RHCs and FQHCs submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 6218 which provides instructions for the calendar year (CY) 2009 Payment Rate Increases for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) services.

**Background**

In accordance with the Social Security Act (Section 1833(f)) (see [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet), the Centers for Medicare & Medicaid Services (CMS) is increasing the calendar year (CY) payment rates for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) effective for services on or after January 1, 2009, through December 31, 2009 (i.e., CY 2009), as follows:

- The RHC upper payment limit per visit is increased from \$75.63 to \$76.84 effective January 1, 2009, through December 31, 2009 (i.e., CY 2009). The 2009 rate reflects a 1.6 percent increase over the 2008 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by the Social Security Act (Section 1833(f)).
- The FQHC **upper payment limit per visit for urban FQHCs** is increased from \$117.41 to \$119.29 effective January 1, 2009, through December 31, 2009 (i.e., CY 2009), and **the maximum Medicare payment limit per visit for rural FQHCs** is increased from \$100.96 to \$102.58 effective January 1, 2009, through December 31, 2009 (i.e. CY 2009). The 2009 FQHC rates reflect a 1.6 percent increase over the 2008 rates, in accordance with the rate of increase in the MEI.

To avoid any unnecessary administrative burden, Medicare contractors will **not** retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. However, they retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

**Additional Information**

The official instruction, CR 6218, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1626CP.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.

## APPLICATION OF THE HOSPITAL OUTPATIENT QUALITY DATA REPORTING PROGRAM UNDER THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6072  
Related CR Release Date: August 15, 2008  
Related CR Transmittal #: R368OTN

Related Change Request (CR) #: 6072  
Effective Date: January 1, 2009  
Implementation Date: January 5, 2009

**Provider Types Affected**

Hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

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

This article is based on Change Request (CR) 6072 regarding application of the Hospital Outpatient Quality Data Reporting Program to services paid under the Hospital OPPS, effective for services rendered on or after January 1, 2009.

**CAUTION – What You Need to Know**

Effective for OPPS services furnished on or after January 1, 2009, 'subsection (d) hospitals' that have failed to submit timely outpatient hospital quality data as required in the Social Security Act (Section 1833(t)(17)(A)) will receive payment under the OPPS that reflects **a two percent deduction from the annual OPPS update** for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edits. Hospitals that are not required to submit quality data (i.e. that are not 'subsection (d) hospitals') will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPPS (e.g. Indian Health service hospitals).

**GO – What You Need to Do**

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

**Background**

As a condition for receiving the full market basket update on their Inpatient Prospective Payment System (IPPS) payments, all hospitals defined as 'subsection (d) hospitals', are required to report hospital quality data:

- In a timely manner, and
- In a way that passes the Centers for Medicare & Medicaid Services (CMS) validation edits for inpatients receiving services in the hospital.

Effective for services furnished on or after January 1, 2009, this policy will also apply to services paid under OPSS to 'subsection (d) hospitals'.

'Subsection (d) hospitals' have the same definition for hospitals paid under the OPSS as for hospitals paid under the IPPS. Specifically, 'subsection (d) hospitals' are defined in the Social Security Act (Section 1886(d)(1)(B);

[http://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm](http://www.ssa.gov/OP_Home/ssact/title18/1886.htm) on the Internet) as hospitals that are located in the fifty states or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children's and cancer hospitals or hospital units. In other words, the provision does not apply to hospitals and hospital units excluded from the IPPS, or to hospitals located in Maryland, Puerto Rico, or the U.S. territories.

CR 6072 announces that, effective for OPSS services furnished on or after January 1, 2009, **'subsection (d) hospitals' that have failed to submit timely outpatient hospital quality data** as required in the Social Security Act (Section 1833(t)(17)(A);

[http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet) **will receive payment under the OPSS that reflects a two percent deduction from the annual OPSS update for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edit. Where hospitals are required to report the quality data and fail to do so, the OPSS Pricer will assign a new return code of 11 (Reduced for absent quality reporting) when a payment APC on a line has a status indicator equal to P, S (if APC is not 1491-1537), T (if APC is not 1539-1574), V, or X.**

Hospitals that are not required to submit quality data (i.e. that are not 'subsection (d) hospitals') will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPSS (e.g. Indian Health service hospitals).

CMS will send your FI or MAC a file of hospitals to which the reduction will apply as soon as the list is available. This is expected to be on or about December 1 of each year. Should a 'subsection (d) hospital' later be determined to have met the criteria after publication of this list, their status will be changed and FIs/MACs will be notified.

For new hospitals, FIs/MACs will provide information to CMS (or a CMS-designated contractor) to allow contact with the new facilities to inform them of the Hospital Quality Initiative.

**Additional Information**

The official instruction, CR 6072, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R368OTN.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.

**FEE SCHEDULE UPDATE FOR 2009 FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)**

~CMS MLN Matters~  
~Part A & Part B~

**MLN Matters Number: MM6270**  
**Related CR Release Date: November 7, 2008**  
**Related CR Transmittal #: R1630CP**

**Related Change Request (CR) #: 6270**  
**Effective Date: January 1, 2009**  
**Implementation Date: January 5, 2009**

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 6270 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

**Background**

The update process for the DMEPOS fee schedule is contained in section 60, Chapter 23 of the Medicare Claims Processing Manual, which is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website. Other information on the fee schedule, including access to the DMEPOS fee schedules is at [http://www.cms.hhs.gov/DMEPOSFeeSched/01\\_overview.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp) on the CMS Website. The key points of CR6270 are as follows:

- The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

L5993	L5994	L5995	L7611	L7612	L7613
L7614	L7621	L7622			

- For gap-filling purposes, the 2008 deflation factors by payment category are:

0.500 for Oxygen	0.504 for Capped Rental	0.505 for Prosthetics and Orthotics	0.641 for Surgical Dressings	0.697 for Parental and Enteral Nutrition
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- The fee schedule amounts for HCPCS code **K0672** (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.
- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.
- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 Quarterly Update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008 will not be adjusted.

#### ***2009 Fee Schedule Updates following the Enactment of the Medicare Improvements for Patients and Providers Act (MIPPA)***

- MIPPA of 2008 mandates a fee schedule covered item **update of -9.5% for 2009 for items included in round 1 of the DMEPOS Competitive Bidding Program**. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.
- Items selected for competitive bidding in 2008 will receive a **-9.5%** update for 2009 with the **exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444**. These 6 oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a 0% update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the -9.5%, even though they are competitive bid items.
- Non-competitive bid items will receive a 5.0% covered item update for 2009.

#### ***New KE Modifier and the KL Modifier***

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid Under Round One of the DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment).

To accommodate the fee schedule updates required per the MIPPA, CMS is adding the KE modifier to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. For example, HCPCS code E0981 *Wheelchair Accessory, Seat Upholstery, Replacement Only, Each* can be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with the KE modifier will receive a 5% covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the KE modifier will receive the MIPPA-required 9.5% reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code

(K0835 thru K0864), claims for the PMD accessory code should be submitted without the KE modifier. If such claims are submitted with the KE modifier, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without the KE modifier, but with the KC modifier when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a non-competitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without the KC modifier, but with the KE modifier.

For the aforementioned reasons, CMS is also adding the KE modifier to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without the KE modifier. Suppliers should bill codes A4636 and A4637 with the KE modifier when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without the KE modifier when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a non-competitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the KE modifier. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with the BA modifier, but without the KE modifier. When code E0776 is used with non-competitively bid parenteral nutrient codes, suppliers should bill code E0776 without the BA modifier, but with the KE modifier.

Further instruction on the use of the KE modifier with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Website.

**Note:** Suppliers should not use the KE modifier on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.

With CR 6270, CMS is also adding the KL modifier to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in MLN Matters article MM5641 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf>), suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, the KL modifier has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use the KL modifier on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts.

**Note:** Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

### **Competitive Bidding Items from 2008 Impacted by 2009 Pricing**

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the - 9.5% covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in **Attachment A** of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Website.

#### **Product Category 1—Oxygen, Supplies and Equipment** (for the detailed product description of each HCPCS code see **Attachment A**)

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of \$175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of \$175.79 includes the 9.5% covered item reduction ascribed to items selected for competitive bidding in 2008. The previously announced payment amount for 2009 of \$193.21 did not include the 9.5% reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

#### **Product Category 2—Standard Power Wheelchairs, Scooters, and Related Accessories** (for the detailed product description of each HCPCS code see **Attachment A**)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1016	E1020	E1028
E2208	E2209	E2210	E2361	E2363	E2365	E2366	E2367
E2368	E2369	E2370	E2371	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602	E2603	E2604	E2605
E2606	E2607	E2608	E2611	E2612	E2613	E2614	E2615
E2616	E2619	E2620	E2621	K0015	K0017	K0018	K0019
K0020	K0037	K0038	K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735	K0736	K0737	K0800
K0801	K0802	K0806	K0807	K0808	K0813	K0814	K0815
K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826
K0827	K0828	K0829					

**Product Category 3—Complex Rehabilitative Power Wheelchairs and Related Accessories** (for the detailed product description of each HCPCS code see **Attachment A**)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1002	E1003	E1004
E1005	E1006	E1007	E1008	E1010	E1016	E1020	E1028
E1029	E1030	E2208	E2209	E2210	E2310	E2311	E2321
E2322	E2323	E2324	E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2373 KC	E2374	E2375	E2376	E2377
E2381	E2382	E2383	E2384	E2385	E2386	E2387	E2388
E2389	E2390	E2391	E2392	E2394	E2395	E2396	E2601
E2602	E2603	E2604	E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020	K0037	K0038	K0039
K0040	K0041	K0042	K0043	K0044	K0045	K0046	K0047
K0050	K0051	K0052	K0053	K0098	K0195	K0733	K0734
K0735	K0736	K0737	K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848	K0849	K0850	
K0851	K0852	K0853	K0854	K0855	K0856	K0857	K0858
K0859	K0860	K0861	K0862	K0863	K0864		

**Product Category 4—Mail-Order Diabetic Supplies** (for the detailed product description of each HCPCS code see **Attachment A**)

A4233 KL	A4234 KL	A4235 KL	A4236 KL	A4253 KL	A4256 KL	A4258 KL	A4259 KL
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**Product Category 5—Enteral Nutrients, Equipment, and Supplies** (for the detailed product description of each HCPCS code see **Attachment A**)

B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088
B4149	B4150	B4152	B4153	B4154	B4155	B9000	B9002
E0776							

**Product Category 6—Continuous Positive Airway Pressure Devices, Respiratory Assist Devices, and Related Supplies and Accessories** (for the detailed product description of each HCPCS code see **Attachment A**)

A4604	A7030	A7031	A7032	A7033	A7034	A7035	A7036
A7037	A7038	A7039	A7044	A7045	A7046	E0470	E0471
E0472	E0561	E0562	E0601				

**Product Category 7—Hospital Beds and Related Supplies** (for the detailed product description of each HCPCS code see **Attachment A**)

E0250	E0251	E0255	E0256	E0260	E0261	E0265	E0266
E0271	E0272	E0280	E0290	E0291	E0292	E0293	E0294
E0295	E0296	E0297	E0300	E0301	E0302	E0303	E0304
E0305	E0310	E0316	E0910	E0911	E0912	E0940	

**Product Category 8—Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories** (for the detailed product description of each HCPCS code see **Attachment A**)

A6550	A7000	E2402
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**Product Category 9—Walkers and Related Supplies** (for the detailed product description of each HCPCS code see **Attachment A**)

A4636	A4637	E0130	E0135	E0140	E0141	E0143	E0144	E0147
E0148	E0149	E0154	E0155	E0156	E0157	E0158	E0159	

**Product Category 10—Support Surfaces** (for the detailed product description of each HCPCS code see **Attachment A**)

E0193	E0277	E0371	E0372	E0373
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**Billing Instructions for Power Wheelchair Harness (HCPCS code E2313)**

The April Quarterly Update for the 2007 DMEPOS Fee Schedule included instructions for suppliers to submit claims for the electronics necessary to **upgrade from a non-expandable controller to an expandable controller at initial issue using HCPCS code E2399. This instruction was intended as a temporary measure** until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power Wheelchair Accessory, Harness For Upgrade to Expandable Controller, Including all Fasteners, Connectors and Mounting Hardware, Each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.
- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.
- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-Contractual Obligation denials.

**Additional Information**

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.

For complete details regarding this Change Request (CR) please see the official instruction (CR6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Website.

## FISCAL YEAR (FY) 2009 INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS), LONG TERM CARE HOSPITAL (LTCH) PPS, AND INPATIENT PSYCHIATRIC FACILITY (IPF) PPS CHANGES

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6189

Related CR Release Date: October 3, 2008

Related CR Transmittal #: R1610CP

Related Change Request (CR) #: 6189

Effective Date: Discharges on or after October 1, 2008

Implementation Date: October 6, 2008

**EDITOR'S NOTE:** WPS Medicare originally published this MLN article in the November 2008 *Communiqué*. We are republishing this article to include the attachments referenced in the article.

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 6189 which outlines changes for IPPS hospitals for FY 2009. The policy changes for FY 2009 appeared in the Federal Register on August 19, 2008, and the final IPPS rates will be available on the Centers for Medicare & Medicaid Services (CMS) Website prior to October 1, 2008. CR 6189 also addresses changes to Medicare Severity Diagnosis Related Groups (MS-DRGs) and ICD-9-CM coding that affects LTCH PPS, and IPF PPS. The LTCH PPS rate changes occurred on July 1, 2008.

### Background

Change Request (CR) 6189 announces changes for IPPS hospitals for FY 2009. The policy changes for FY 2009 appeared in the Federal Register on August 19, 2008, and the final IPPS rates will be available on the CMS Website prior to October 1, 2008. All items covered in CR 6189 are effective for hospital discharges occurring on or after October 1, 2008, unless otherwise noted.

**Note:** The final rule of August 19, 2008, did not include the implementation of Public Law 110-275, which extended the hospital reclassification provisions of section 508 and certain special exceptions through September 30, 2009.

Please refer to Transmittal 1547, CR 6114, published on July 2, 2008, for LTCH policy changes. An MLN Matters article related to that transmittal is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6114.pdf> on the CMS Website. The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2008. IPF PPS rate changes occurred on July 1, 2008. Refer to Transmittal 1543, CR 6077, published on June 27, 2008 for IPF PPS policy changes. An MLN Matters article related to that transmittal is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6077.pdf> on the CMS site. The changes conveyed in CR6189 follow.

**ICD-9-CM Changes**

The ICD-9-CM coding changes are effective October 1, 2008. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 1, 2008, Federal Register. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 1, 2008, Federal Register notice is available at [http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f\\_2.pdf](http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f_2.pdf) on the CMS Website.

**Software Updates**

The LTCH Pricer has been updated with the MS-LTC-DRG table and weights.

A new MS-DRG GROUPER software package, Version 26.0, is effective for discharges on or after October 1, 2008. The GROUPER 26.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare Code Editor (MCE), Version 25.0, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2008.

The IPPS PRICER FY 08 used for discharges occurring on or after October 1, 2007, through September 30, 2008 incorporates a correction to Puerto-Rico rates. All IPPS Puerto Rico claims with discharges on or after October 1, 2007, through September 30, 2008, will be reprocessed by Medicare using the corrected rates, which are as follows:

- **Wage Index (WI) > 1** = Labor Share (LS) = \$1,471.10 Non Labor Share (NLS) = \$901.64
- **WI < 1** = LS = \$1,392.80 NLS = \$979.94
- The revised FY 2008 Puerto Rico capital rate is \$202.89.

An IPPS PRICER FY 09 will be used for discharges occurring on or after October 1, 2008. The FY 09 IPPS Pricer package processes bills with discharge dates on or after October 1, 2003.

**Rates**

<b>Standardized Amount Update Factor</b>	1.036, but 1.016 for hospitals that do not submit quality data.
<b>Hospital Specific Update Factor</b>	1.036, but 1.016 for hospitals that do not submit quality data.
<b>Common Fixed Loss Cost Outlier Threshold</b>	\$20,045.00
<b>Federal Capital Rate</b>	\$424.17
<b>Puerto Rico Capital Rate</b>	\$198.77
<b>Outlier Offset-Operating National</b>	0.948996
<b>Outlier Offset-Operating Puerto Rico</b>	0.954304
<b>IME Formula</b>	$1.35 \times [(1 + \text{resident-to-bed ratio}) \cdot 405 - 1]$
<b>MDH/SCH Budget Neutrality Factor</b>	0.998795

**Operating**

**RATES W/ FULL Market Basket (MB) & WI Greater Than 1**

	<b>LS</b>	<b>NLS</b>
<b>National</b>	3,574.50	1,553.91
<b>PR National</b>	3,574.50	1,553.91
<b>PR Specific</b>	1,507.82	924.15

**RATES W/ FULL MB & WI Less Than 1**

	<b>LS</b>	<b>NLS</b>
<b>National</b>	3,179.61	1,948.80
<b>PR National</b>	3,179.61	1,948.80
<b>PR Specific</b>	1,427.57	1,004.40

**RATES W/ REDUCED MB & WI Greater Than 1**

	<b>LS</b>	<b>NLS</b>
<b>National</b>	3,505.49	1,523.91
<b>PR National</b>	3,574.50	1,553.91
<b>PR Specific</b>	1,507.83	924.15

**RATES W/ REDUCED MB & WI Less Than 1**

	<b>LS</b>	<b>NLS</b>
<b>National</b>	3,118.23	1,911.17
<b>PR National</b>	3,179.61	1,948.80
<b>PR Specific</b>	1,427.57	1,004.40

**Cost-of-Living Adjustment (COLA) Factors: Alaska and Hawaii Hospitals**

<b>Area</b>	<b>COLA Factor</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	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

**Postacute Transfer Policy**

The DRGs determined in the post acute care policy have been modified due to changes made to the MS-DRG system. All post acute transfer MS-DRGs for FY 2009 are listed in Table 5 of the IPPS final rule, which is available at [http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f\\_2.pdf](http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f_2.pdf) on the CMS Website.

**New Technology Add-On Payment**

Effective for discharges on or after October 1, 2008, the new technology add-on payment for FY 2009 will be triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and diagnosis code reflecting clinical trial--V70.7 (Examination of participant in clinical trial). If the criteria are met, Medicare will make a maximum add-on payment of up to \$53,000 (that is, 50 percent of the estimated operating costs of the device) per case for cases that involve this technology. If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of 50 percent of the costs of the new medical service or technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

**State Rural Floor Budget Neutrality Adjustment Factors**

The inclusion of the new Pricer table (see attachment C of CR 6189), "State Rural Floor Budget Neutrality Adjustment Factors", is due to new regulations for the wage index, at 42 CFR 412.64(e)(4), that were implemented in the FY 2009 IPPS final rule (73 FR 48570). The table in ATTACHMENT C of CR 6189 lists the blended overall rural floor budget neutral factors that are to be applied onto the wage index based on the provider's geographic state location. Attachment C is available at the end of this article. The wage table loaded for the FY 2009 PRICER contains wage index values PRIOR to the application of the blended overall rural floor budget neutrality factors. PRICER is applying the budget neutrality factors from ATTACHMENT C to the wage index within the PRICER payment logic. The wage index tables printed in the FY 2009 Federal Register Final Rule Notice already have the blended overall rural floor budget neutrality factors applied. To confirm the wage index PRICER uses in calculating payments with the wage index printed in the Federal Register, you must take the wage index from PRICER and multiply it by the appropriate factor from ATTACHMENT C.

**Hospital-Acquired Conditions (HAC) and Present on Admission (POA) Indicator Reporting**

The Deficit Reduction Act of 2005 (DRA) requires a payment adjustment in Medicare DRG payment for certain hospital-acquired conditions. CMS has titled the program, "Hospital-Acquired Conditions and Present on Admission Indicator Reporting".

**Hospital-Acquired Conditions:**

- Are high cost or high volume or both,
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
- Could reasonably have been prevented through the application of evidence-based guidelines.

Section 5001(c) of the DRA required the Secretary of the Department of Health and Human Services to identify, by October 1, 2007, at least two conditions that for discharges occurring on or after October 1, 2008, IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as though the secondary diagnosis were not present.

Version 26.0 of the Grouper will include logic to determine the appropriate MS-DRG based on the HAC and POA logic. The Hospital-Acquired Conditions payment provision applies only to IPPS hospitals. At this time, the following hospitals are **exempt** from the HAC payment provision:

- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children’s Inpatient Facilities
- Inpatient Rehabilitation Facilities (IRFs)
- Psychiatric Hospitals

**The current proposed list of impacted HACs is in the following table:**

Hospital-Acquired Condition	Complicating condition (CC) or major complicating condition (MCC) (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Stage III & IV Pressure Ulcers	707.23 (MCC) 707.24 (MCC)
Falls and Trauma Fractures Dislocations Intracranial Injuries Crushing Injuries Burns Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 CC Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and any one of the following procedures: 36.10- 36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23, 81.24, 81.31-81.38, 81.83, or 81.85.
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis of 278.01 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) and one of the following procedure codes: 00.85-00.87, 81.51-81.52, and 81.54

For more information on HAC POA, see <http://www.cms.hhs.gov/HospitalAcqCond/> on the CMS Website.

### **Provider Specific Information**

Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2009 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.196 and the capital ceiling is 0.145.

### **CBSA Designations**

Attachment A of CR 6189 shows the IPPS providers that will be receiving a "special" wage index for FY 2009 (i.e., receives an out-commuting adjustment under section 505 of the MMA). For any provider with a Special Wage Index from FY 2008, FIs and A/B MACs shall remove that special wage index, by entering zeros in the field unless they receive a new special wage index as listed in Attachment A of CR 6189 is duplicated at the end of this article and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.pdf> on the CMS Website.

### **Low Volume Hospitals**

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

### **Hospital Quality Initiative**

The FIs and A/B MACs will also identify each hospital that meets the criteria for higher payments per MMA Quality standards. The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org/pgri> on the internet. This Website is expected to be updated in September 2009. Attachment B of CR 6189 includes the list of providers that did not meet the criteria for FY 09 and which will not receive the 2.0% annual payment update for FY 2009. (CR 6189 is included at the end of this article and is available <http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.pdf> on the CMS Website.) Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Website and FIs and A/B MACs will update their records accordingly.

FIs and A/B MACs will identify new hospitals to the Quality Improvement Organizations (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting.

This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

### **Capital IPPS Adjustment for Indirect Medical Education (IME)**

As established in the FY 2008 IPPS final rule with comment period (72 FR 47401), in accordance with the regulations at §412.322(c), for discharges occurring during FY 2009,

the capital IME adjustment factor equals one-half the current adjustment (that is the amount computed under §412.322(b)). This 50 percent reduction in the capital IME adjustment factor is reflected in the Pricer.

### Re-Basing of Sole Community Hospitals (SCHs)

Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) provides an option to SCHs that would allow them to rebase their hospital specific rates using data from their FY 2006 cost report (cost reporting periods beginning on or after October 1, 2005, and on or before September 30, 2006) if this results in a payment increase. If the FY 2006 cost report data amount is used, it would be effective for the SCH's cost reporting periods beginning on or after January 1, 2009.

### The Inpatient Psychiatric Facility (IPF) PPS Update

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2009 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. **This table is only a listing of FY 2009 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes** classified in the MS-DRGs. When coded as a principal diagnosis, these codes receive the correlating DRG adjustment.

Diagnosis Code	Description	MS-DRG
046.11	Variant Creutzfeldt-Jakob disease	056, 057
046.19	Other and unspecified Creutzfeldt-Jakob disease	056, 057
046.71	Gerstman-Sträussler-Scheinker syndrome	056, 057
046.72	Fatal familial insomnia	056, 057
046.79	Other and unspecified prion disease of central nervous system	056, 057

For FY 2009, the diagnosis code of 046.1 (Jakob-Creutzfeldt (MS-DRG 056, 057)) is invalid and no longer applicable for the DRG adjustment.

Since CMS does not plan to update the regression analysis until it analyzes IPF PPS data, the MS-DRG adjustment factors, shown in the following table, are effective October 1, 2008, and will continue to be paid for RY 2009.

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02

MS-DRG	MS-DRG Descriptions	Adjustment Factor
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

### Comorbidity Adjustment Update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes for certain comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

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

The IPF PPS uses the MS-Severity DRG coding system, in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. CMS is using the FY 2009 GROUPE, Version 26.0 which is effective for discharges occurring on or after October 1, 2008.

CR 6189 contains three tables that list the FY 2009 new, revised and invalid ICD-9-CM diagnosis codes, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2009 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

### Additional Information

The official instruction, CR 6189, issued to your FI or A/B MAC regarding this change is <http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.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.

## Attachment A

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
010008	1	0.7792
010015	1	0.7664
010021	1	0.7670
010027	1	0.7644
010032	1	0.7943
010038	1	0.8025
010040	1	0.8022
010045	1	0.7840
010046	1	0.8022
010047	1	0.7745
010049	1	0.7644
010078	1	0.8025
010091	1	0.7664
010109	1	0.8023
010110	1	0.7833
010125	1	0.8094
010128	1	0.7664
010129	1	0.7752
010138	1	0.7684
010146	1	0.8025
010150	2	0.8464
020008	2	1.2554
030067	1	0.9122
040047	1	0.7762
040067	1	0.7652
040081	1	0.8002
050002	1	1.5640
050007	1	1.5211
050009	1	1.4125
050013	1	1.4125
050043	1	1.5640
050069	1	1.1985
050070	1	1.5211
050075	1	1.5640
050084	1	1.2104
050089	1	1.1983
050090	1	1.5282
050099	1	1.1983
050113	1	1.5211
050129	1	1.1983
050136	1	1.5282
050140	1	1.1983
050167	1	1.2104
050168	1	1.1985
050173	1	1.1985
050174	1	1.5282
050193	1	1.1985

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
050194	1	1.5954
050195	1	1.5640
050211	1	1.5640
050224	1	1.1985
050226	1	1.1985
050230	1	1.1985
050242	1	1.5954
050245	1	1.1983
050264	1	1.5640
050272	1	1.1983
050279	1	1.1983
050283	1	1.5640
050289	1	1.5211
050291	1	1.5282
050298	1	1.1983
050300	1	1.1983
050305	1	1.5640
050313	1	1.2104
050320	1	1.5640
050325	1	1.2005
050327	1	1.1983
050336	1	1.2104
050348	1	1.1985
050366	1	1.1987
050385	1	1.5282
050426	1	1.1985
050444	1	1.2288
050488	1	1.5640
050512	1	1.5640
050517	1	1.1983
050526	1	1.1985
050543	1	1.1985
050547	1	1.5282
050548	1	1.1985
050549	2	1.4681
050551	1	1.1985
050567	1	1.1985
050570	1	1.1985
050580	1	1.1985
050584	1	1.1983
050586	1	1.1983
050589	1	1.1985
050603	1	1.1985
050609	1	1.1985
050667	1	1.4125
050678	1	1.1985
050690	1	1.5282

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
050693	1	1.1985
050714	1	1.5954
050720	1	1.1985
050744	1	1.1985
050745	1	1.1985
050746	1	1.1985
050747	1	1.1985
050748	1	1.2104
050754	1	1.5211
050758	1	1.1983
060010	1	0.9722
060030	1	0.9722
060075	2	1.1062
060119	1	0.9722
070001	2	1.2600
070005	2	1.2600
070006	2	1.3003
070010	1	1.2869
070016	2	1.2600
070017	2	1.2600
070018	2	1.3003
070019	2	1.2600
070022	2	1.2600
070028	1	1.2869
070031	2	1.2600
070033	1	1.2869
070034	2	1.3003
070039	2	1.2600
090003	1	1.0684
090005	1	1.0684
090006	1	1.0684
090008	1	1.0684
100290	1	0.8954
110100	1	0.8604
110101	1	0.7881
110142	1	0.7999
110190	1	0.8055
110205	1	0.8321
130024	1	0.8243
130066	1	0.9470
140001	1	0.8767
140026	1	0.8713
140116	1	1.0289
140161	1	0.8566
140176	1	1.0289
140234	1	0.8713
150022	1	0.8623
150034	2	1.0274

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
150072	1	0.8570
160013	1	0.9133
160030	1	0.9412
160032	1	0.9189
160040	2	0.8954
160064	2	1.0364
160067	2	0.8954
160080	1	0.9020
170150	1	0.8221
180064	1	0.8213
180070	1	0.8139
180079	1	0.8158
190034	1	0.7845
190044	1	0.7917
190050	1	0.7700
190053	1	0.7757
190054	1	0.7741
190078	1	0.7843
190099	1	0.7845
190116	1	0.7741
190133	1	0.7758
190140	1	0.7691
190145	1	0.7746
190190	1	0.7731
190218	2	0.8519
190246	1	0.7731
190277	1	0.8043
200032	1	0.8943
220002	1	1.1359
220011	1	1.1359
220046	2	1.1366
220049	1	1.1359
220063	1	1.1359
220070	1	1.1359
220082	1	1.1359
220084	1	1.1359
220098	1	1.1359
220101	1	1.1359
220105	1	1.1359
220171	1	1.1359
220175	1	1.1359
230003	2	1.0355
230004	2	1.0355
230005	1	0.9336
230013	2	1.0769
230019	2	1.0769
230020	2	1.0163
230024	2	1.0163

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
230029	2	1.0769
230036	2	1.0769
230038	2	1.0355
230053	2	1.0163
230059	2	1.0355
230066	2	1.0355
230071	2	1.0769
230072	2	1.0355
230075	1	1.0048
230089	2	1.0163
230093	1	0.8921
230097	2	1.0355
230104	2	1.0163
230106	2	1.0355
230119	2	1.0163
230130	2	1.0769
230135	2	1.0163
230146	2	1.0163
230151	2	1.0769
230165	2	1.0163
230174	2	1.0355
230176	2	1.0163
230207	2	1.0769
230217	1	1.0048
230223	2	1.0769
230236	2	1.0355
230254	2	1.0769
230269	2	1.0769
230270	2	1.0163
230273	2	1.0163
230277	2	1.0769
240018	1	0.9891
240044	1	0.9711
240117	1	0.9613
240211	1	0.9898
250002	2	0.8418
250078	2	0.8217
250122	2	0.8418
250128	1	0.8071
250162	1	0.8879
260059	1	0.8492
260064	1	0.8504
260097	1	0.8715
260116	1	0.8502
260163	1	0.8502
270002	2	0.8738
270012	2	0.8738
270023	2	0.9011

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
270032	2	0.9011
270057	2	0.9011
280077	1	0.8808
280123	1	0.8851
310021	2	1.2762
310028	2	1.2762
310050	2	1.2762
310051	2	1.2762
310060	2	1.2762
310115	2	1.2762
310120	2	1.2762
320011	1	0.9171
320018	1	0.8858
320085	1	0.8858
330010	1	0.8330
330023	2	1.3003
330027	1	1.2809
330033	1	0.8486
330047	1	0.8330
330049	2	1.2791
330067	2	1.3003
330106	2	1.4928
330126	2	1.2791
330132	1	0.8394
330135	2	1.2791
330144	1	0.8319
330151	1	0.8319
330167	1	1.2809
330175	1	0.8523
330181	1	1.2809
330182	1	1.2809
330198	1	1.2809
330205	2	1.2791
330225	1	1.2809
330259	1	1.2809
330264	2	1.2686
330276	1	0.8299
330331	1	1.2809
330332	1	1.2809
330372	1	1.2809
340002	2	0.9431
340020	1	0.8756
340024	1	0.8777
340037	1	0.8762
340038	1	0.8853
340104	1	0.8762
340133	1	0.8860
340151	1	0.8652

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
350002	2	0.8229
350003	2	0.8229
350006	2	0.8229
350015	2	0.8229
350017	2	0.8229
350019	2	0.7944
350030	2	0.8229
360002	1	0.8711
360040	1	0.8957
360044	1	0.8697
360070	1	0.8824
360071	1	0.8605
360084	1	0.8824
360100	1	0.8824
360131	1	0.8824
360151	1	0.8824
360156	1	0.8689
370023	1	0.8030
370065	1	0.8036
370072	1	0.8198
370083	1	0.7991
370100	1	0.8040
370156	1	0.8061
370169	1	0.8103
370214	1	0.8061
380090	2	1.2797
390001	2	0.9642
390003	2	0.9642
390008	1	0.8393
390045	2	0.9642
390052	1	0.8380
390056	1	0.8369
390072	2	0.9642
390095	2	0.9642
390117	1	0.8335
390119	2	0.9642
390122	1	0.8386
390125	1	0.8355
390137	2	0.9642
390146	1	0.8355
390150	1	0.8364
390169	2	0.9642
390185	2	0.9797
390192	2	0.9642
390201	1	0.9503
390236	1	0.8336
390237	2	0.9642
390270	2	0.9797

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
390316	1	0.9492
420002	1	0.9535
420019	1	0.8746
420027	1	0.9805
420043	1	0.8745
420053	1	0.8623
420054	1	0.8590
420082	1	0.9569
430005	2	0.9467
430008	2	0.9373
430013	2	0.9373
430015	2	0.9344
430048	2	0.9344
430060	2	0.9344
430064	2	0.9344
430094	1	0.8525
440007	1	0.8162
440012	1	0.7952
440016	1	0.8087
440017	1	0.7952
440031	1	0.7962
440033	1	0.7970
440047	1	0.8281
440050	1	0.7952
440051	1	0.8025
440057	1	0.7964
440070	1	0.8052
440081	1	0.7995
440084	1	0.7968
440109	1	0.8013
440115	1	0.8281
440137	1	0.8681
440174	1	0.8255
440176	1	0.7952
440180	1	0.7970
440181	1	0.8308
440182	1	0.8087
450032	1	0.8378
450059	1	0.8992
450072	2	0.9890
450090	1	0.8774
450144	1	0.8683
450163	1	0.8178
450192	1	0.8395
450194	1	0.8337
450210	1	0.8275
450236	1	0.8513
450270	1	0.8395

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
450370	1	0.8359
450438	1	0.8359
450451	1	0.8660
450460	1	0.8177
450497	1	0.8499
450539	1	0.8191
450573	1	0.8250
450591	2	0.9890
450615	1	0.8157
450641	1	0.8499
450698	1	0.8251
450755	1	0.8400
450838	1	0.8250
450884	1	0.8716
450888	1	0.9674
460017	1	0.8746

Provider Number	Value to enter in Special Pay Indicator	Value to enter in Special Wage Index
470003	2	1.1366
490001	2	0.8651
490084	1	0.8219
490110	1	0.8277
500019	1	1.0273
500041	1	1.1431
510012	1	0.7744
520035	1	0.9477
520044	1	0.9477
520057	1	0.9594
520095	1	0.9594
530008	2	0.9271
530010	2	0.9271
530015	2	1.0353
670015	1	0.9674
670023	1	0.9674

**Attachment B**

Provider ID	Provider Name
30073	TUBA CITY REGIONAL HEALTH CARE CORPORATION
30074	SELLS INDIAN HEALTH SERVICE HOSPITAL
30077	SAN CARLOS HOSPITAL
30113	WHITERIVER PHS INDIAN HOSPITAL
50018	PACIFIC ALLIANCE MEDICAL CENTER
50091	COMMUNITY AND MISSION HOSPITAL OF HUNTINGTON PARK
50257	GOOD SAMARITAN HOSPITAL
50320	ALAMEDA COUNTY MEDICAL CENTER
50325	TUOLUMNE GENERAL MEDICAL FACILITY
50377	CHOWCHILLA DISTRICT MEM HOSPITAL
50378	PACIFICA HOSPITAL OF THE VALLEY
50430	MODOC MEDICAL CENTER
50456	SOUTH BAY COMMUNITY HOSPITAL, L P
50545	LANTERMAN DEVELOPMENTAL CENTER
50546	PORTERVILLE DEVELOPMENTAL CENTER
50548	FAIRVIEW DEVELOPMENTAL CENTER
50578	MARTIN LUTHER KING, JR - HARBOR HOSPITAL
50662	AGNEWS STATE HOSPITAL
50668	LAGUNA HONDA HOSPITAL & REHABILITATION CENTER
50698	SAN DIEGO HOSPICE & PALLIATIVE CARE ACUTE CARE CEN
50708	FRESNO SURGICAL HOSPITAL
50758	MONTCLAIR HOSPITAL MEDICAL CENTER
70038	CONNECTICUT HOSPICE INC.
90008	UNITED MEDICAL CENTER
100108	TRINITY COMMUNITY HOSPITAL
100134	ED FRASER MEMORIAL HOSPITAL
100279	GULF COAST HOSPITAL
100298	FLORIDA STATE HOSPITAL UNIT 31 MED
120004	WAHIAWA GENERAL HOSPITAL

Provider ID	Provider Name
140033	VISTA MEDICAL CENTER WEST
140094	ST MARY & ELIZABETH MED CTR-CLAREMONT CAMPUS
140205	SWEDISH AMERICAN MEDICAL CENTER BELVIDERE
150164	MONROE HOSPITAL
170150	SOUTH CENTRAL KS REGIONAL MED CENTER
190037	SOUTH CAMERON MEMORIAL HOSPITAL
190151	RICHARDSON MEDICAL CENTER
190267	FAIRWAY MEDICAL CENTER
220153	SOLDIERS HOME OF HOLYOKE
220154	SOLDIERS HOME IN MASSACHUSETTS
220172	UNIVERSITY HEALTH SERVICES
230135	HENRY FORD COTTAGE HOSPITAL
230144	FOREST HEALTH MEDICAL CENTER
250023	PEARL RIVER COUNTY HOSPITAL
250051	KILMICHAEL HOSPITAL
250060	JEFFERSON COUNTY HOSPITAL
250079	SHARKEY ISSAQUENA COMMUNITY HOSPITAL
250125	GULF COAST MEDICAL CENTER
250127	CHOCTAW HEALTH CENTER
250151	ALLIANCE HEALTH CENTER
250152	MISSISSIPPI METHODIST REHAB CTR
280119	P H S INDIAN HOSPITAL
280127	LINCOLN SURGICAL HOSPITAL
290002	SOUTH LYON MEDICAL CENTER
290020	PRIMECARE NEVADA, INC., DBA NYE REGIONAL MEDICAL CENTER
290027	GROVER C DILS MEDICAL CENTER
290042	HARMON MEDICAL AND REHABILITATION HOSPITAL
290053	ST ROSE DOMINICAN HOSPITAL-SAN MARTIN
320030	ARTESIA GENERAL HOSPITAL
330029	SHEEHAN MEMORIAL HOSPITAL
330094	COLUMBIA MEMORIAL HOSPITAL
330406	SUNNYVIEW HOSPITAL AND REHABILITATION CENTER
330407	EDDY COHOES REHABILITATION CENTER
340104	CRAWLEY MEMORIAL HOSPITAL
340137	BROUGHTON HOSPITAL-MEDICAL UNIT
340138	CENTRAL REGIONAL HOSPITAL
340168	WILMINGTON TREATMENT CENTER
350064	US PUBLIC HEALTH SERVICE INDIAN HOSPITAL
360187	SPRINGFIELD REGIONAL MEDICAL CENTER
360247	WOODS AT PARKSIDE,THE
360258	BARIX CLINICS OF OHIO, LLC
360274	MEDICAL CENTER AT ELIZABETH PLACE
360276	HMHP ST ELIZABETH BOARDMAN HEALTH CENTER
370169	COMMUNITY HOSPITAL LAKEVIEW
370171	W W HASTINGS INDIAN HOSPITAL
370199	LAKESIDE WOMEN'S HOSPITAL
370214	LINDSAY MUNICIPAL HOSPITAL
370220	ORTHOPEDIC HOSPITAL
390112	WINDBER HOSPITAL
390176	COMMONWEALTH MEDICAL CENTER

Provider ID	Provider Name
390312	CANCER TREATMENT CENTERS OF AMERICA
390317	DSI OF BUCKS COUNTY
430081	PINE RIDGE IHS HOSPITAL
430093	SAME DAY SURGERY CENTER LLC
440223	BAPTIST WOMENS TREATMENT CTR MURFREESBORO
440224	BAPTIST WOMEN'S TREATMENT CENTER
450162	HIGHLAND COMMUNITY HOSPITAL
450270	LAKE WHITNEY MEDICAL CENTER
450330	OAKBEND MEDICAL CENTER
450379	R.H.D. MEMORIAL MEDICAL CENTER
450446	RIVERSIDE GENERAL HOSPITAL
450683	RENAISSANCE HOSPITAL TERRELL
450758	HEALTHSOUTH DALLAS REHAB HOSPITAL
450839	SHELBY REGIONAL MEDICAL CENTER
460018	KANE COUNTY HOSPITAL
460035	BEAVER VALLEY HOSPITAL
490104	HIRAM W DAVIS MEDICAL CENTER
490105	SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
490108	CENTRAL VIRGINIA TRAINING CENTER
490129	CAPITAL HOSPICE - HALQUIST MEMORIAL INPATIENT CENTER
490134	PIEDMONT GERIATRIC HOSPITAL
490135	CATAWBA HOSPITAL
500143	PROV ST PETER CHEMICAL DEPENDENCY CENTER
520203	SELECT SPECIALTY HOSPITAL - MADISON
670007	BEAUMONT BONE & JOINT INSTITUTE
670010	DENTON REHABILITATION HOSPITAL L.P.
670017	HEALTHSOUTH REHABILITATION HOSPITAL
670018	DOCTORS DIAGNOSTIC HOSPITAL
670021	INNOVA HOSPITAL SAN ANTONIO
670027	APEX HOSPITAL - TMC

**Attachment C**

STATE CODE	FACTOR	STATE CODE	STATE NAME
01	0.9968	01	ALABAMA
02	0.9951	02	ALASKA
03	0.9968	03	ARIZONA
04	0.9968	04	ARKANSAS
05	0.9931	05	CALIFORNIA
06	0.9962	06	COLORADO
07	0.9900	07	CONNECTICUT
08	0.9968	08	DELAWARE
09	0.9968	09	DISTRICT OF CO
10	0.9964	10	FLORIDA
11	0.9968	11	GEORGIA
12	0.9968	12	HAWAII
13	0.9968	13	IDAHO
14	0.9968	14	ILLINOIS
15	0.9967	15	INDIANA
16	0.9944	16	IOWA
17	0.9968	17	KANSAS

STATE CODE	FACTOR	STATE CODE	STATE NAME
18	0.9968	18	KENTUCKY
19	0.9967	19	LOUISIANA
20	0.9968	20	MAINE
21	1.0000	21	MARYLAND
22	0.9968	22	MASSACHUSETTS
23	0.9968	23	MICHIGAN
24	0.9968	24	MINNESOTA
25	0.9968	25	MISSISSIPPI
26	0.9968	26	MISSOURI
27	0.9968	27	MONTANA
28	0.9968	28	NEBRASKA
29	0.9968	29	NEVADA
30	0.9924	30	NEW HAMPSHIRE
31	0.9946	31	NEW JERSEY
32	0.9966	32	NEW MEXICO
33	0.9968	33	NEW YORK
34	0.9968	34	NORTH CAROLINA
35	0.9968	35	NORTH DAKOTA
36	0.9966	36	OHIO
37	0.9968	37	OKLAHOMA
38	0.9954	38	OREGON
39	0.9968	39	PENNSYLVANIA
40	0.9968	40	PUERTO RICO
41	0.9968	41	RHODE ISLAND
42	0.9964	42	S CAROLINA
43	0.9968	43	SOUTH DAKOTA
44	0.9963	44	TENNESSEE
45	0.9968	45	TEXAS
46	0.9968	46	UTAH
47	0.9968	47	VERMONT
48	1.0000	48	VIRGIN ISLANDS
49	0.9968	49	VIRGINIA
50	0.9964	50	WASHINGTON
51	0.9964	51	WEST VIRGINIA
52	0.9966	52	WISCONSIN
53	0.9968	53	WYOMING
55	0.9931	55	CALIFORNIA
56	1.0000	56	CANADA
59	1.0000	59	MEXICO
64	1.0000	64	AMERICAN SAMOA
65	1.0000	65	GUAM
66	1.0000	66	MARIANAS ISLANDS
67	0.9968	67	TEXAS
68	0.9964	68	FLORIDA
69	0.9964	69	FLORIDA
70	0.9968	70	KANSAS
71	0.9967	71	LOUISIANA
72	0.9966	72	OHIO
73	0.9968	73	PENNSYLVANIA
74	0.9968	74	TEXAS

STATE CODE	FACTOR	STATE CODE	STATE NAME
75	0.9931	75	CALIFORNIA
76	0.9944	76	IOWA
77	0.9968	77	MINNESOTA
78	0.9968	78	ILLINOIS
80	1.0000	80	MARYLAND

## MEDICARE PAYMENT FOR AIR AMBULANCE SERVICES UNDER SECTION 146(B)(1) OF THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6214  
 Related CR Release Date: October 17, 2008  
 Related CR Transmittal #: R387OTN

Related Change Request (CR) #: 6214  
 Effective Date: July 1, 2008  
 Implementation Date: January 5, 2009

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 6214, which alerts providers to the fact that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.

Be aware that upon the implementation date of January 5, 2009, in addition to the successful installation of the revised calendar year (CY) 2008 ZIP Code File, your Medicare contractor will mass-adjust all air ambulance claims with dates of service on or after July 1, 2008, through December 31, 2008, which were previously paid under an urban ZIP code that was considered rural on December 31, 2006. In addition, the revised ZIP Code File will be used to process such claims that were not already processed.

### Key Points of CR6214

Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) further amends the designation of rural areas for air ambulance services.

- The statute specifies that any area that was designated as a rural area, as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.
- Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, CMS has re-established the "rural" indicator on the ZIP code file for air ambulance services, effective July 1, 2008.

- Your Medicare contractor will process air ambulance transport and mileage claims (i.e., A0430, A0431, A0435, A0436), in accordance with these revised designations.

### Background

The Ambulance Fee Schedule was implemented in April 2002 based on a Final Rule published in the Federal Register (67 Fed. Reg. 9100 (February 27, 2002)). The elements of this final rule allowed for payment for various ground ambulance services and rotary and fixed wing air ambulance services under a fee schedule. The payment for these services is based on the type of service provided and on the geographical points of pick up. The final rule also establishes increased payment for services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance.

When the fee schedule was implemented, a rural area was defined as one that was outside any area defined by the Office of Management and Budget as a Metropolitan Statistical Area, (MSA) or a New England County Metropolitan Area (NECMA). The definition of “rural” also included the Goldsmith Modification. The Goldsmith Modification was developed because of the need to identify small towns and rural areas within large metropolitan counties. Some of these communities were isolated from central areas with health services because of distance or other physical features. The urban and rural areas were identified for payment purposes by a nexus of the ZIP code file and the ambulance fee schedule. The ZIP code file is updated quarterly.

Another final rule published in 71 Fed. Reg. 69713 (December 1, 2006), revised the geographic designations for urban and rural areas as set forth in OMB’s Core- Based Statistical Areas (CBSAs) standard. It added the definition of “urban area” as defined by the Executive Office of Management and Budget (OMB). In addition, it removed the definition of “Goldsmith modification” and amended the definition of “rural area” to include areas determined to be rural under the most recent version of the Goldsmith modification. Updating the MSA definition to conform with OMB’s CBSA-based geographic area designations, coupled with updating the Goldsmith Modification (that is, using the current Rural Urban Commuting Areas (RUCAs) version, as discussed in Section III.B.1.b of the final rule), more accurately reflected the contemporary urban and rural nature of areas across the country for ambulance payment purposes and made ambulance fee schedule payments more accurate. These changes became effective January 1, 2007.

### Additional Information

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

To see the official instruction (CR6214) issued to your Medicare Carrier, FI, or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R387OTN.pdf> on the CMS Website.

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

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6212  
Related CR Release Date: October 24, 2008  
Related CR Transmittal #: R389OTN

Related Change Request (CR) #: 6212  
Effective Date: July 1, 2008  
Implementation Date: October 24, 2008,  
unless otherwise noted below

**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 Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the MPFS

**Provider Action Needed**

**STOP – Impact to You**

This article is based on Change Request (CR) 6212, which announces the new 2008 MPFS payment rates effective for dates of service July 1, 2008, through December 31, 2008. Please note that Medicare contractors have already implemented the actions annotated in this article.

**CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) directed Medicare contractors to revert back to the 0.5 percent payment rates that were previously in place until June 30, 2008, and to use those rates through December 31, 2008. In addition, carriers/Part B MACs are using the same rates as used for January 1 through June 30, 2008, to make payments, where appropriate, to Ambulatory Surgical Centers (ASCs) for services rendered from July 1 through December 31, 2008. This reflects a continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services. CMS also provided revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008.

**GO – What You Need to Do**

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

**Background**

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. The -10.6 percent Medicare Physician Fee Schedule (MPFS) that took effect on July 1, 2008, was changed back to the January-June 2008 rates, which reflect an update of 0.5 percent. CMS directed **Medicare contractors** to revert back to the 0.5 percent payment files that were previously in place until June 30, 2008. The new MPFS rates are retroactive to July 1, 2008.

Consistent with the new legislation, **carriers/Part B MACs** are using the same fees as used for January 1 through June 30, 2008, to make payments to **ambulatory surgical centers**

(ASCs) for July 1 through December 31, 2008. Those fees reflect the continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services.

**Fiscal intermediaries/Part A MACs** also have reverted back to the fees that were in effect from January 1, 2008, through June 30, 2008.

In addition, based on the new legislation, CMS provided Medicare contractors with new revised **fees for selected mental health codes** that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008, and Medicare contractors are currently paying the new fees.

After Medicare contractors began paying claims at the new rates, they began to identify any MPFS claims that were paid at the -10.6 percent rate for dates of service on and after July 1, 2008. Contractors are in the process of automatically adjusting those claims, and must complete the adjustments no later than September 30, 2008.

There may be some claims that cannot be automatically adjusted. Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1, 2008, and later billed with a submitted charge at least at the level of the January 1 through June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount requires providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced non-participation amount also will need to request an adjustment.

Contractors are following the normal process for transmitting the adjusted claims to supplemental insurers, where appropriate. Contractors disclosed the new MPFS rates on their Websites by July 23, 2008.

#### **Additional Information**

The official instruction, CR 6212, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R389OTN.pdf> on the CMS Website.

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

**PAYMENT FOR IMPLANTED PROSTHETIC DEVICES FOR MEDICARE  
PART B INPATIENTS****~ Revised CMS MLN Matters ~****~ Part A ~**

**MLN Matters Number: MM6050 Revised**  
**Related CR Release Date: November 3, 2008**  
**Related CR Transmittal #: R1628CP**

**Related Change Request (CR) #: 6050**  
**Effective Date: January 1, 2009**  
**Implementation Date: January 5, 2009**

**Note:** This article was revised on November 4, 2008, to reflect revisions made to CR6050, which was revised to reflect that the new C-Code discussed in CR6050 is HCPCS code C9899. This article was revised accordingly. In addition, the CR release date, transmittal number, and Web address for accessing CR6050 were revised. All other information remains the same.

**Provider Types Affected**

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for implanted prosthetic devices provided to Medicare beneficiaries under Part B.

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

This article is based on Change Request (CR) 6050 which clarifies payment for implanted prosthetic devices for Medicare Part B inpatients.

**CAUTION – What You Need to Know**

Change Request (CR) 6050 revises the Medicare Claims Processing Manual (Chapter 4, Section 240) to provide instructions regarding how contractors are to establish the payment to be made under the Outpatient Prospective Payment System (OPPS) for implanted prosthetic devices that are furnished to Medicare beneficiaries who, on the date that the device is implanted, are hospital inpatients without Part A coverage of services, but with Part B coverage,

**GO – What You Need to Do**

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

**Background**

The Centers for Medicare & Medicaid Services (CMS) can designate medical and other health services (that are payable under the Medicare Outpatient Prospective Payment System (OPPS)) for beneficiaries who are hospital inpatients with Medicare Part B benefits, but who do not have Part A benefits. See the Social Security Act (Section 1833(t)(2)(A)) at [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet.

The Medicare Benefits Policy Manual (Chapter 2, Section 10) includes implanted prosthetic devices in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries who are inpatients of a hospital but who are not covered under Medicare Part A at the time of implantation, but who do have Part B coverage, on the day that they receive an implanted prosthetic device. The processing of claims for these services is discussed in the Medicare Claims Processing Manual (Chapter 4, Section 240). Under

Medicare PPSes, payment for these items is packaged into payment for the procedure in which they are implanted.

Change Request (CR) 6050 revises the Medicare Claims Processing Manual, (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 240 (Inpatient Part B Hospital Services)) to provide instructions regarding how Medicare contractors are to establish payment for providers subject to the OPPS for implanted prosthetic devices that are furnished to Medicare beneficiaries who are hospital inpatients not having Part A coverage of services on the date that the device is implanted.

Specifically, the manual is revised to specify that **providers must submit these services on a 12X type of bill, reporting a new HCPCS code (C9899)** that will be effective for services furnished on and after January 1, 2009, **when they furnish an implanted prosthetic device** to a Medicare beneficiary

- Who is a hospital inpatient, but
- Who does not have Part A coverage of inpatient services on the date that the implanted prosthetic device is furnished.

By reporting the new C-code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Chapter 6, Section 10 of the Medicare Benefits Policy Manual.

The manual is also revised to specify that Medicare contractors will:

- Determine if the device meets the definition for an implanted prosthetic device, and if so,
- Establish the payment to be made for the device.

Medicare contractors will first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in Chapter 6, Section 10, of the Medicare Benefits Policy Manual. If the item does not meet the criteria for coverage as an implantable prosthetic device, the Medicare contractor will deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in Chapter 6, Section 10 of the Medicare Benefits Policy Manual.

Once the Medicare contractor determines that the device is covered, it will then determine the appropriate payment amount for the device.

The contractor shall begin this process by determining if the device has pass through status under the OPPS. If so, the contractor will establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio.

Where the device does not have pass through status under the OPPS, the contractor will set the payment amount for the device at the lesser of the amount for the device, in the DMEPOS fee schedule, where there is such an amount or the actual charge for the device. Where there is no amount for the device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. Payment would be made at the lesser of the contractor established payment rate for the specific device or the actual charge for the device.

In setting a Medicare contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

See <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> for the amount of reduction to the APC payment that would apply in these cases. From this OPPS Web page, select "Device, Radiopharmaceutical and Procedure Edits" from the list on the left side of the page. Open the file "Procedure to Device edits" to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS Web page and open the file "APC Adjustments in Cases of Full Credit/No Cost or Partial Credit for Replaced Devices." Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the device described by the new C code. It would be reasonable to set this amount as the payment for a device furnished to a Part B inpatient.

For example, if the new C-code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in "remarks") the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4881.77. It would therefore be reasonable for the FI or MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to \$4881.77. In this case the coinsurance would be \$936.75 (20 percent of \$4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount or the contractor established amount, or the actual charge where applicable), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Note that Medicare contractors will deny payment for an item reported with the new C9899 if they determine that it does not meet the definition of an implanted prosthetic device that is implanted in the body at least temporarily. On such denials, the remittance advice remark code will show N180 (This item or service does not meet the criteria for the category under which it was billed.) with a group code or PR (Patient Responsibility) and a claim adjustment reason code of 96 (Non-covered charges).

Medicare contractors will also deny payment if they or Medicare systems determine that the beneficiary was in a covered Part A stay on the date of service of the item reported with the new C9899. Such denials will contain a remittance advice remark code of M2 (Not paid separately when the patient is an inpatient), a group code of CO (Contract Obligation) and a claim adjustment reason code of 96 (Non-covered charges).

**Note:** The revised Medicare Claims Processing Manual, (Chapter 4 Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 240 (Inpatient Part B Hospital Services)) is included as an attachment to CR 6050.

**Additional Information**

The official instruction, CR 6050, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1628CP.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.

## PAYMENT OF ASSISTANT AT SURGERY SERVICES IN A METHOD II CRITICAL ACCESS HOSPITAL (CAH)

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6123  
Related CR Release Date: October 24, 2008  
Related CR Transmittal #: R1620CP

Related Change Request (CR) #: 6123  
Effective Date: January 1, 2008  
Implementation Date: April 6, 2009

**Provider Types Affected**

Method II CAHs (to whom physicians and non-physician practitioners rendering assistant in surgery services have reassigned their billing rights) who bill Medicare Fiscal Intermediaries (FI) or Part A/B Medicare Administrative Contractors A/B MAC for such assistant at surgery services

**What You Need to Know**

CR 6123, from which this article is taken, implements the amount Medicare pays to providers who (having reassigned their billing rights to Method II CAHs) render assistance at surgery services in that hospital.

The payment amount for a physician assisting at surgery is calculated as follows:

The facility specific Medicare Physician Fee Schedule (MPFS) amount **multiplied by** a 16 percent assistant at surgery reduction amount **minus** the deductible and coinsurance, then **multiplied by** 115 percent,

**OR**

**((MPFS X .16) – (deductible and coinsurance)) X 1.15.**

The payment amount for a physician assistant (PA), nurse practitioner NP, or clinical nurse specialist (CNS) assisting at surgery is calculated as follows:

The facility specific MPFS amount **multiplied by** a 16 percent assistant at surgery reduction amount **multiplied by** an 85 percent non-physician practitioner reduction **minus** the deductible and coinsurance, **then multiplied by** 115 percent,

**OR**

**((MPFS X .16 X .85) – (deductible and coinsurance)) X 1.15).**

Make sure that your billing staffs are aware of this method of calculating payment for assistance in surgery services.

**Background**

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to that CAH. When they elect to reassign these billing rights, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X).

CR 6123, from which this article is taken, implements the payment amount for providers who (having reassigned their billing rights to Method II CAH) render assistance at surgery services.

CR6123 also updates *Medicare Claims Processing Manual* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) by adding the following new sections:

- 250.9 (Coding Assistant at Surgery Services Rendered in a Method II CAH);
- 250.9.1 (Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery);
- 250.9.2 (Payment of Assistant at Surgery Services Rendered in a Method II CAH);
- 250.9.3 (Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages);
- 250.9.4 (Assistant at Surgery Services in a Method II CAH Teaching Hospital); and
- 250.9.5 (Review of Supporting Documentation for Assistant at Surgery Services in a Method II CAH).

**CAH Impact Summary**

Assistant at surgery services are those services rendered by physicians or non-physician practitioners who actively assist the physician in charge of performing a surgical procedure. When a Method II CAH bills for a surgical procedure on TOB 85X with RC 96X, 97X or 98X, and an appropriate assistant at surgery modifier (explained below), Medicare will pay the CAH for the assistant at surgery services it provides (if the rendering a physician or non-physician practitioner has reassigned their billing rights to the CAH).

You should be aware that Section 1862 of the Social Security Act (the Act) stipulates that payment can only be made for care that is reasonable and necessary; and specifically, Section 1862(15)(A) of the Act addresses the services of an assistant at surgery and when those services are statutorily excluded. In conformance with this stipulation, Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if assistant at surgery services are reasonable and necessary for a specific HCPCS/CPT code. You can find the MPFSDB is located at [http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp) on the Centers for Medicare & Medicaid Services (CMS) Website.

**Payment**

Medicare pays for a surgical assistant when the procedure is authorized for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS).

To facilitate payment, CMS (under authority of 42 CFR Section 414.40) has established uniform national definitions of services, codes to represent services, and payment modifiers to the codes, to include the use of payment modifiers for assistant at surgery services.

To bill for these services, you should use Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available). You should also use Modifier AS when you need to indicate that a PA, NP or CNS served as the assistant at surgery. Be aware that when you use Modifier AS, you must also use Modifier 80, 81, or 82 because using these modifiers without modifier AS indicates that a physician served as the surgical assistant. Claims that you submit with modifier AS and without modifier 80, 81, or 82 will be returned to you.

### Payment Amount Calculation

Section 1834(g)(2)(B) of the Social Security Act (the Act) requires that professional services included within outpatient CAH services be paid at 115 percent of the amount that would otherwise be paid if such services were not included in the outpatient CAH services.

Other sections of the Act address the specific payment for surgical assistance:

- Section 1848(i)(2)(B) stipulates that if, for a physician-furnished surgery service, a separate payment is made to a physician providing surgical assistance, the fee schedule amount will not exceed 16 percent of the fee schedule amount; and
- Section 1833(a)(1)(O)(ii) states that when the surgical assistance is provided by a PA, NP or CNS, payment is the lesser of the actual charge, or 85 percent of the amount that would otherwise be paid to a physician serving as an assistant at surgery.

The payment amount for a physician assisting at surgery is calculated as follows:

The facility specific Medicare Physician Fee Schedule (MPFS) amount **multiplied by** a 16 percent assistant at surgery reduction amount **minus** the deductible and coinsurance, **then multiplied by** 115 percent,

**OR**

**((MPFS X .16) – (deductible and coinsurance)) X 1.15.**

The payment amount for a PA, NP, or CNS assisting at surgery is calculated as follows:

The facility specific MPFS amount **multiplied by** a 16 percent assistant at surgery reduction amount **multiplied by** an 85 percent non-physician practitioner reduction **minus** the deductible and coinsurance, **and then multiplied by** times 115 percent,

**OR**

**((MPFS X .16 X .85) – (deductible and coinsurance)) X 1.15).**

You should be aware that FIs and A/B MACs will suspend and assign a unique reason code in the 5XXXX series to assistant at surgery services on TOB 85X with RC 96X, 97X or 98X and modifier AS, 80, 81 or 82 when the HCPCS/CPT code has a payment policy indicator of '0' (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity). They will pay for these services when medical necessity has been established. Such payment will be based on the lesser of actual charges or the reduced MPFS amount determined by the formulas listed above.

FIs and A/B MACs will return to provider (RTP) claims for assistant at surgery services that you submit on TOB 85X with RC 96X, 97X or 98X and modifier AS, 80, 81 or 82

when the HCPCS/CPT code billed with the modifier has a payment policy indicator of '9' (concept does not apply).

**Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages**

When denying non-covered assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of "0" (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) or '2' (Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid) when an Advance Beneficiary Notice (ABN) was issued, FIs and A/B MACs will use the following MSN and RA messages:

**MSN Messages to the Beneficiary:**

36.1 - Our records show you were informed in writing, before receiving the service, Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

**RA Remark Code**

M38 - The patient is liable for charges for this service as you informed the patient in writing before the service was furnished that we could not pay for it, and the patient agreed to pay.

**RA Group Code**

PR – Patient Responsibility

**RA Claim Adjustment Reason Code**

54 – Multiple physicians/assistants are not covered in this case.

Unless you issue an appropriate ABN, you are liable for non-covered assistant at surgery services with a payment policy indicator of '0' or '2'. When denying non-covered assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' and an ABN was **not** issued, FIs and A/B MACs will use the following MSN and RA messages:

**MSN Messages to the Beneficiary**

36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

**RA Remark Code**

M27 - The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised

due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.

**RA Group Code**

CO – Contractual Obligation

**RA Claim Adjustment Reason Code**

54 – Multiple physicians/assistants are not covered in this case.

When denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '1' (Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid), FIs and A/B MACs will use the following MSN and RA messages:

**MSN Message**

15.11 – Medicare does not pay for an assistant surgeon for this procedure/surgery.

**RA Remark Code**

N425 – Statutorily Excluded Service

**RA Group Code**

PR – Patient Responsibility

**RA Claim Adjustment Reason Code**

54 – Multiple physicians/assistants are not covered in this case.

***Teaching Hospitals Impact Summary***

Providing assistant in surgery services in teaching has some specific requirements. In general, if a hospital has a training program relating to the medical specialty required for the surgical procedure, and a qualified resident is available to provide surgical assistance for a procedure, Section 1842(b)(7)(D) of the Social Security Act stipulates that no payment will be made for the services of a surgical assistant for the procedure. FIs and A/B MACs will process assistant at surgery services furnished in Method II teaching CAHs through the use of modifier 82, which indicates that a qualified resident surgeon was not available.

However, such payments can be made in teaching hospitals under certain circumstances such as exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries), which require immediate treatment; situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician or non-physician provider to assist at surgery even though a qualified resident is available; or if the primary surgeon has an across-the board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Claims will be suspended and developed when billed by Method II teaching CAHs with modifiers AS, 80 or 81 to determine if exceptional medical circumstances existed or the primary surgeon has an across-the board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Given the absence of national policy on this provision, FIs and A/B MACs have the authority to establish procedures to define the appropriate supporting documentation needed to

establish medical necessity, the existence of exceptional medical circumstances or to determine if the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his patients for assistant at surgery services. FIs and A/B MACs will also determine if a clinician or non-clinician medical reviewer will review assistant at surgery services.

Also, keep in mind that FIs and A/B MACs:

- Process assistant at surgery claims for services furnished in a teaching hospital through the use of modifier 82 to indicate that a qualified resident was not available. Modifier 82 is for use only when the basis for payment is the unavailability of qualified residents; and
- Will suspend for review and assign a unique reason code in the 5xxx series to claims that you submit on type of bill 85X with RC 96X, 97X or 98X and modifier AS, 80 or 81, when the HCPCS/CPT code has a payment policy indicator of '0' (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) or '2' (Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid) and the intern to bed ratio is greater than 0 (teaching hospital). Once supporting documentation justifies the services of the assistant at surgery, the FI or A/B MAC will make payment on the claim.

Finally, you should know that FIs and A/B MACs will not search for, and adjust claims that have been paid prior to the implementation date, but will adjust claims that you bring to their attention

#### **Additional Information**

You can find more information about the payment of assistant at surgery services in a Method II CAH by going to CR 6123, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1620CP.pdf> on the CMS Website.

You will find the updated updates *Medicare Claims Processing Manual* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSPS)) Sections 250.9 (Coding Assistant at Surgery Services Rendered in a Method II CAH), 250.9.1 (Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery), 250.9.2 (Payment of Assistant at Surgery Services Rendered in a Method II CAH), 250.9.3 (Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages), and 250.9.4 (Assistant at Surgery Services in a Method II CAH Teaching Hospital).

As mentioned earlier, you can find the assistant at surgery payment policy indicators for HCPCS/CPT on the MPFSD at [http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp) on the CMS Website.

You might also want to look at CR6013 – Physician Fee Schedule Payment Policy Indicator File Record Layout for use in Processing Method II CAH Claims for Professional Services), released May 16, 2008, for more information about the file layout used in processing CAH professional services' claims.

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.

## REASONABLE CHARGE UPDATE FOR 2008 FOR SPLINTS, CASTS, DIALYSIS SUPPLIES, DIALYSIS EQUIPMENT, AND CERTAIN INTRAOCULAR LENSES

~ Revised CMS MLN Matters ~

~ Part A & Part B ~

MLN Matters Number: MM5740 **Revised**  
Related CR Release Date: September 28, 2007  
Related CR Transmittal #: R1344CP

Related Change Request (CR) #: 5740  
Effective Date: January 1, 2008  
Implementation Date: January 7, 2008

**Note:** This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007." All other information is unchanged.

### Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

### Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

### Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: <http://www.gpoaccess.gov/cfr/retrieve.html> on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf> on the CMS Website.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office**. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632

(Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

#### **Dialysis Supplies Billed With AX Modifier**

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

#### **Dialysis Supplies Billed Without AX Modifier**

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

#### **Dialysis Equipment Billed With AX Modifier**

E0210NU	E1632	E1637	E1639
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#### **Dialysis Equipment Billed Without AX Modifier**

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes.

**Contractors** will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article.**

#### **Additional Information**

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and

- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare FI, carrier, DME MAC, 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.

#### Attachment A

**2008 Payment Limits for Splints and Casts**

Code	Payment Limit	Code	Payment Limit
A4565	\$7.38	Q4025	\$32.45
Q4001	\$42.01	Q4026	\$101.30
Q4002	\$158.81	Q4027	\$16.23
Q4003	\$30.18	Q4028	\$50.66
Q4004	\$104.49	Q4029	\$24.81
Q4005	\$11.12	Q4030	\$65.31
Q4006	\$25.08	Q4031	\$12.41
Q4007	\$5.58	Q4032	\$32.65
Q4008	\$12.54	Q4033	\$23.14
Q4009	\$7.43	Q4034	\$57.56
Q4010	\$16.72	Q4035	\$11.57
Q4011	\$3.71	Q4036	\$28.79
Q4012	\$8.36	Q4037	\$14.12
Q4013	\$13.52	Q4038	\$35.37
Q4014	\$22.81	Q4039	\$7.08
Q4015	\$6.76	Q4040	\$17.68
Q4016	\$11.40	Q4041	\$17.16
Q4017	\$7.82	Q4042	\$29.30
Q4018	\$12.47	Q4043	\$8.59
Q4019	\$3.91	Q4044	\$14.66
Q4020	\$6.24	Q4045	\$9.96
Q4021	\$5.78	Q4046	\$16.03
Q4022	\$10.44	Q4047	\$4.97
Q4023	\$2.91	Q4048	\$8.02
Q4024	\$5.22	Q4049	\$1.82

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