The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC (Cahaba)

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com

The Inside Story

News from CMS

ู่️ News Flash Messages from CMS ....................... 1
ู่️ July 2009 Integrated Outpatient Code Editor (IOCE) Specifications Version 10.2 ........ 3
ู่️ Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update .......................... 5
ู่️ July 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files ................................ 8
ู่️ July Quarterly Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) ........................................ 10
ู่️ Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008—CR 6509 RESCINDS AND FULLY REPLACES CR 6404 ........................................ 13
ู่️ Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008—Rescinded ........................................ 15
ู่️ July Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB) ........................................ 16
ู่️ New Drug/Biological Health Care Procedure Code System (HCPCS) Codes for July 2009 Update .......................................................... 18
ู่️ The ICD-10 Clinical Modification/Procedure Coding System (CM/PCS)—The Next Generation of Coding—Revised .................................. 20
ู่️ Influenza Pandemic Emergency - The Medicare Program Prepares—Revised .......... 23
ู่️ Discontinuance of the Unique Physician Identification Number (UPIN) Registry—Revised ........................................ 24
ู่️ Revised Implementation Date for Change Request 6426 ........................................ 26
ู่️ FDA Consumer Alert: Warning Consumers of a Tainted Skin Sanitizer .......................... 27
ู่️ July 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS) ........ 28
ู่️ Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Accreditation Requirements—Revised ..................... 35

News from Cahaba

ู่️ Updated Frequently Asked Questions (FAQs) for Top Inquiries ........................................ 39
ู่️ Quarterly Provider Update ........................................ 40

The Inside Story Continues on the Next Page

Key for Icons:

lığı Home Health Providers
lı Hospitality Providers

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News from Cahaba

- Medicare Credit Balance Quarterly Reminder
- System Availability During the July 4th Holiday
- Availability of the Provider Contact Center (PCC)
- Using the Appropriate Form to Request Assistance with a Transfer Dispute
- Venipuncture… “Is that covered?”
- Widespread Probe Notification for Home Health Providers—Length of Stay Greater Than 999 Days

Cahaba Learning Corner

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ICD-9 Notice
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News Flash Messages from CMS for Home Health and Hospice Providers

Implementation of HIPAA 5010
A Special Edition MLN Matters provider education article is now available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf on the CMS Web site. This Special Edition article alerts providers regarding the implementation of HIPAA 5010 which presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries and outlines how providers need to plan for implementation of these changes.
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Accreditation

Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. While the accreditation process takes on average 6-7 months to complete, the process could take as long as 9 months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application. Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS Web site at:
http://www.cms.hhs.gov/MedicareProviderSupEnroll/DMEPOS_DeemedAccreditationOrganizations.asp

Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Competitive Bidding Program

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, including a requirement that competition to re-bid Round 1 occur in 2009. On January 16, 2009, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period that incorporates into regulations only those provisions of MIPPA related to the DMEPOS competitive bidding program that are self-implementing and necessary to conduct the Round 1 rebid competition in 2009. That rule became effective on April 18, 2009, and is available at http://edocket.access.gpo.gov/2009/pdf/E9-863.pdf on the Internet. It is crucial that DME suppliers be accredited in order to submit bids for the competitive bidding program. Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals/persons exempted from accreditation may be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/DMEPOS_DeemedAccreditationOrganizations.asp on the CMS Web site.

Receive Valuable News and Information from Your Medicare Contractor

Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare administrative contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through Cahaba’s electronic mailing lists, we can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to Cahaba’s Web site and sign up for our E-mail Notification Service.
July 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.2

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: MM6480  Related Change Request (CR) #: 6480
Related CR Release Date: May 15, 2009  Effective Date: July 1, 2009
Related CR Transmittal #: R1739CP  Implementation Date: July 6, 2009

Provider Types Affected
All providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare administrative contractors (MACs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for outpatient services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 6480, which notifies providers that the I/OCE Specifications Version 10.2, is effective July 1, 2009. Be sure billing staffs are aware of these changes.

Background
CR 6480 informs Medicare contractors and providers that the Integrated OCR (I/OCE) will be updated for July 1, 2009. CR 6480 provides the Integrated OCE instructions and specifications for the I/OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. A summary of the changes for July 2009 is within Appendix M of Attachment A of CR 6480 and that summary is captured in the following key points.

Key Points of CR 6480
Medicare has made the following Healthcare Common Procedure Coding System/Ambulatory Payment Class/Status Indicator (HCPCS/APC/Status Indicator) changes:

Added APCs

- APC 01268 (Xyntha, inj), APC 01269 (Alloskin skin sub) and APC 01270 (Alloderm skin sub) with Status Indicators (SI) = K have been added effective July 1, 2009.
- APC 09250 (Artiss fibrin sealant), APC 09251 (Inj, C1 esterase inhibitor), APC 09252 (Injection, plerixafor), APC 09253 (Injection, temozolomide), APC 09360 (SurgiMend, neonatal), APC 09361 (NeuraMend nerve wrap), APC 09362 (Implnt,bone void filler-strip), APC 09363 (Integra Meshed Bil Wound Mat), and APC 09364 (Porcine implant, Permacol) with SIs = G have been added effective July 1, 2009.
**APC Description Changes**
- APC 09358 previously had a description of SurgiMend, 0.5cm² and now has a new description of SurgiMend, fetal.
- APC 09359 previously had a description of Implant, bone void filler and now has a new description of Implant, bone void filler-putty.

**New HCPCS**
(All new HCPCS under this heading have an effective date of July 1, 2009.)
- HCPCS 0199T (Physiologic tremor record), with an APC of 00215 and an SI = S.
- HCPCS 0200T (Perq sacral augmt unilat inj), with an APC of 00049 and an SI = T.
- HCPCS 0201T (Perq sacral augmt bilat inj), with an APC of 00050 and an SI = T.
- HCPCS 0202T (Post vert arthrplst 1 lumbar), with an APC of 00000 and an SI = C.
- HCPCS 90670 (Pneumococcal vacc, 13 val im), with an APC of 00000 and an SI = E.
- HCPCS C9250 (Artiss fibrin sealant), with an APC of 09250 and an SI = G.
- HCPCS C9251 (Inj, C1 esterase inhibitor), with an APC of 09251 and an SI = G.
- HCPCS C9252 (Injection, pleixafor), with an APC of 09252 and an SI = G.
- HCPCS C9253 (Injection, temozolomide), with an APC of 09253 and an SI = G.
- HCPCS C9360 (SurgiMend, neonatal), with an APC of 09360 and an SI = G.
- HCPCS C9361 (NeuraMend nerve wrap), with an APC of 09361 and an SI = G.
- HCPCS C9362 (Implnt, bon void filler-strip), with an APC of 09362 and an SI = G.
- HCPCS C9363 (Integra Meshed Bil Wound Mat), with an APC of 09363 and an SI = G.
- HCPCS C9364 (Porcine implant, Permacol), with an APC of 09364 and an SI = G.
- HCPCS Q2023 (Xyntha, inj), with an APC of 01268 and an SI = K.
- HCPCS Q4115 (Alloskin skin sub), with an APC of 01269 and an SI = K.
- HCPCS Q4116 (Alloderm skin sub), with an APC of 01270 and an SI = K.

**HCPCS Description Changes**
- HCPCS C9358 had an old description of SurgiMend, 0.5cm² and now has a new description of SurgiMend, fetal effective July 1, 2008.
- HCPCS C9359 had an old description of Implant, bone void filler and now has a new description of Implant, bone void filler-putty effective October 1, 2008.
- HCPCS 4266F had an old description of No wet-dry dressings Rx-recmd and now has a new description of No Wet-dry dressings Rx-recmd effective July 1, 2009.

**HCPCS Changes to Edit and/or SI**
- HCPCS 99251, 99252, 99253, 99254 and 99255 were changed from SI = M to SI = C effective January 1, 2009.
- HCPCS K0740 was changed from SI = Y to SI = E and from Old Edit = 61 to New Edit = 9 effective April 1, 2009.

**Modifier Additions**
- Modifiers PA, PB and PC are valid modifiers effective January 1, 2009.
- Modifiers PI and PS are valid modifiers effective April 1, 2009.
Deleted Modifier
- Modifier K8 has been deleted from the list of valid modifiers effective April 1, 2009.

Correct Coding
- Version 15.1 of the National Correct Coding Initiatives will be implemented effective with the July 2009 version of the I/OCE.

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

The official instruction (CR 6480) issued to your Medicare MAC and/or FI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1739CP.pdf on the CMS Web site.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: MM6453
Related CR Release Date: May 15, 2009
Related CR Transmittal #: R1734

Related Change Request (CR) #: 6453
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare administrative contractors (MACs), durable medical equipment Medicare administrative contractors (DME MACs)) for services.

Provider Action Needed
CR 6453, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2009. Be sure billing staff are aware of these changes.

Background
The reason and remark code sets are used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is
maintained by CMS, and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month.

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes. The CARC list is also updated 3 times a year – in early March, July, and November along with the RARC list.

Both code lists are posted at [http://www.wpc-edi.com/Codes](http://www.wpc-edi.com/Codes) on the Internet. The lists at the end of the “Additional Information” section of this article summarize the latest changes to these lists, as announced in CR 6453.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at [http://www.cmsremarkcodes.info](http://www.cmsremarkcodes.info) on the Internet. Note that this Web site does not replace the Washington Publishing Company (WPC) site. That site is [http://www.wpc-edi.com/Codes](http://www.wpc-edi.com/Codes) and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

**Additional Information**

As a reminder, CR 6336 noted that CARC 17 is being replaced with 2 new CARCs:

- **226:** Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

- **227:** Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

To see the official instruction (CR 6453) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to [http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.pdf) on the CMS Web site.


If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

**New Codes - CARC:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date per WPC Posting</th>
</tr>
</thead>
<tbody>
<tr>
<td>229</td>
<td>Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer’s cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.</td>
<td>1/25/2009</td>
</tr>
<tr>
<td>230</td>
<td>No available or correlating CPT/HCPCS code to describe this service, Note: Used only by Property and Casualty</td>
<td>1/25/2009</td>
</tr>
</tbody>
</table>
### Modified Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date per WPC Posting</th>
</tr>
</thead>
<tbody>
<tr>
<td>187</td>
<td>Health Savings account payments. This change to be effective 10/1/2009: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)</td>
<td>1/25/2009</td>
</tr>
</tbody>
</table>

### Deactivated Codes - CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)</td>
<td>7/1/2009</td>
</tr>
<tr>
<td>156</td>
<td>Flexible spending account payments. Note: Use code 187.</td>
<td>10/1/2009</td>
</tr>
</tbody>
</table>

### New Codes - RARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Medicare Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>N516</td>
<td>Records indicate a mismatch between the submitted NPI and EIN.</td>
<td>NO</td>
</tr>
<tr>
<td>N517</td>
<td>Resubmit a new claim with the requested information</td>
<td>YES</td>
</tr>
<tr>
<td>N518</td>
<td>No separate payment for accessories when furnished for use with oxygen equipment.</td>
<td>YES</td>
</tr>
</tbody>
</table>

### Modified Codes – RARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Medicare Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>M6</td>
<td>Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Start: 01/01/1997 Last Modified: 03/01/2009 Notes: (Modified 4/1/07, 3/1/2009)</td>
<td>YES</td>
</tr>
<tr>
<td>N109</td>
<td>This claim/service was chosen for complex review and was denied after reviewing the medical records. Start: 02/28/2002</td>
<td>YES</td>
</tr>
<tr>
<td>N387</td>
<td>Alert: Submit this claim to the patient’s other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 04/01/2007</td>
<td>YES</td>
</tr>
</tbody>
</table>
Deactivated Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Medicare Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>N515</td>
<td>Alert: Submit this claim to the patient’s other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead)</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Start: 11/01/2008</td>
<td>Stop: 10/01/2009</td>
</tr>
</tbody>
</table>

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July 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: [http://www.cms.hhs.gov/MLNMattersArticles](http://www.cms.hhs.gov/MLNMattersArticles)

MLN Matters® Number: MM6471
Related Change Request (CR) #: 6471
Related CR Release Date: May 15, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1737
Implementation Date: July 6, 2009

Provider Types Affected
All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors (MACs), fiscal intermediaries (FIs), carriers, durable medical equipment Medicare administrative contractors (DME MACs) or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on CR 6471 and instructs Medicare contractors to download and implement the July 2009 ASP drug pricing file for Medicare Part B drugs; and if released by the CMS, also the revised April 2009, January 2009, October 2008 and July 2008, files. They will use the July 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2009, with dates of service July 1, 2009, through September 30, 2009.

Background
Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid
based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The Food and Drug Administration (FDA) approval;
- Therapeutic equivalents as determined by the FDA; and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of NOC HCPCS codes.

**ASP Methodology**

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End Stage Renal Disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities); and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5%. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4%. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106% of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule and they are stated in the Medicare Claims Processing Manual, (CMS Pub. 100-04), Ch. 17, § 20.1.3 and may be reviewed at [http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf) on the CMS Web site.

**Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir**

Physicians (or a practitioner described in Section 1842(b) (18) (C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient’s illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished
incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Use of Quarterly Payment Files
The following table shows how the quarterly payment files will be applied:

<table>
<thead>
<tr>
<th>Payment Allowance Limit Revision Date</th>
<th>Applicable Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2009 ASP and ASP NOC files</td>
<td>July 1, 2009, through September 30, 2009</td>
</tr>
<tr>
<td>April 2009 ASP and ASP NOC files</td>
<td>April 1, 2009, through June 30, 2009</td>
</tr>
<tr>
<td>January 2009 ASP and NOC Files</td>
<td>January 1, 2009, through March 31, 2009</td>
</tr>
<tr>
<td>October 2008 ASP and NOC Files</td>
<td>October 1, 2008, through December 31, 2008</td>
</tr>
</tbody>
</table>

NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim makes these determinations.

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.


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July Quarterly Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: [http://www.cms.hhs.gov/MLNMattersArticles](http://www.cms.hhs.gov/MLNMattersArticles)

MLN Matters® Number: MM6511
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1754CP
Related Change Request (CR) #: 6511
Effective Date: January 1, 2009, for implementation of fee schedule amounts for codes in effect then; April 1, 2009, for code K0739; July 1, 2009, for all other changes
Implementation Date: July 6, 2009
**Provider Types Affected**
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

**Provider Action Needed**
This article is based on CR 6511 and alerts providers that 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 DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is located in §60, Ch. 23 of the *Medicare Claims Processing Manual* and is located at [http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf) on the CMS Web site. 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 Web site.

**Key Points of CR 6511**
- The following table identifies the 2009 fees for the Healthcare Common Procedure Codes System (HCPCS) codes K0739/E1340. The * denotes revised for the 2009 fee schedule.

<table>
<thead>
<tr>
<th>State</th>
<th>K0739/E1340</th>
<th>State</th>
<th>K0739/E1340</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK*</td>
<td>25.27</td>
<td>MT</td>
<td>13.41</td>
</tr>
<tr>
<td>AL*</td>
<td>13.41</td>
<td>NC</td>
<td>13.41</td>
</tr>
<tr>
<td>AR*</td>
<td>13.41</td>
<td>ND*</td>
<td>16.72</td>
</tr>
<tr>
<td>AZ*</td>
<td>16.59</td>
<td>NE</td>
<td>13.41</td>
</tr>
<tr>
<td>CA*</td>
<td>20.58</td>
<td>NH*</td>
<td>14.40</td>
</tr>
<tr>
<td>CO*</td>
<td>13.41</td>
<td>NJ*</td>
<td>18.10</td>
</tr>
<tr>
<td>CT*</td>
<td>22.40</td>
<td>NM*</td>
<td>13.41</td>
</tr>
<tr>
<td>DC*</td>
<td>13.41</td>
<td>NV*</td>
<td>21.37</td>
</tr>
<tr>
<td>DE*</td>
<td>24.71</td>
<td>NY*</td>
<td>24.71</td>
</tr>
<tr>
<td>FL*</td>
<td>13.41</td>
<td>OH*</td>
<td>13.41</td>
</tr>
<tr>
<td>GA*</td>
<td>13.41</td>
<td>OK</td>
<td>13.41</td>
</tr>
<tr>
<td>HI*</td>
<td>16.59</td>
<td>OR</td>
<td>13.41</td>
</tr>
<tr>
<td>IA*</td>
<td>13.41</td>
<td>PA*</td>
<td>14.40</td>
</tr>
<tr>
<td>ID*</td>
<td>13.41</td>
<td>PR</td>
<td>13.41</td>
</tr>
<tr>
<td>IL</td>
<td>13.41</td>
<td>RI*</td>
<td>15.99</td>
</tr>
<tr>
<td>IN</td>
<td>13.41</td>
<td>SC</td>
<td>13.41</td>
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<tr>
<td>KS</td>
<td>13.41</td>
<td>SD*</td>
<td>14.99</td>
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<tr>
<td>KY</td>
<td>13.41</td>
<td>TN</td>
<td>13.41</td>
</tr>
<tr>
<td>LA</td>
<td>13.41</td>
<td>TX</td>
<td>13.41</td>
</tr>
<tr>
<td>MA*</td>
<td>22.40</td>
<td>UT*</td>
<td>13.45</td>
</tr>
<tr>
<td>MD</td>
<td>13.41</td>
<td>VA</td>
<td>13.41</td>
</tr>
<tr>
<td>ME*</td>
<td>22.40</td>
<td>VI</td>
<td>13.41</td>
</tr>
</tbody>
</table>
The 2009 allowed payment amounts for codes E1340/K0739 are revised as part of this quarterly update to reflect updates that were brought to CMS’ attention. The allowed payment amounts (listed above) for codes E1340/K0739 are effective as follows:

- For claims with dates of service from January 1, 2009, through March 31, 2009, submitted using HCPCS code E1340 (Repair or Non-routine Service for DME Requiring the Skill of a Technician, Labor Component, Per 15 Minutes); and
- For claims with dates of service from April 1, 2009, through December 31, 2009, submitted using code K0739 (Repair or Non-routine Service for DME Other Than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes).

Medicare contractors will adjust previously processed claims for HCPCS code E1340/K0739 with dates of service on or after January 1, 2009, through June 30, 2009, if they are resubmitted as adjustments. HCPCS codes A6545, E0656, E0657 and L0113 were added to the HCPCS file effective January 1, 2009. The fee schedule amounts for these HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2009. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for the above codes with dates of service on or after January 1, 2009, that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.

As part of this update CMS is adding the AW modifier to the fee schedule file for HCPCS code A6545 Gradient Compression Wrap, Non-Elastic, Below Knee, 30-50 MM HG, Each. Code A6545 is covered when it is used in the treatment of an open venous stasis ulcer. Currently, code A6545 is noncovered for the following conditions:

- Venous insufficiency without stasis ulcers, prevention of stasis ulcers, prevention of the reoccurrence of stasis ulcers that have healed, and treatment of lymphedema in the absence of ulcers. In these situations, since an ulcer is not present, the gradient compression wraps do not meet the definition of a surgical dressing. Suppliers are advised that when the non-elastic gradient compression wrap code A6545 is used in the treatment of an open venous stasis ulcer, it must be billed with the AW modifier. Claims for code A6545 that do not meet the covered indications should be billed without the AW modifier and as such, will be denied as non-covered.

As part of this update, the fee schedule amounts for HCPCS code K0606 (Automatic External Defibrillator, with Integrated Electrocardiogram Analysis, Garment Type) billed without the KF modifier are being removed from the DMEPOS fee schedule file.


<table>
<thead>
<tr>
<th>State</th>
<th>K0739/E1340</th>
<th>State</th>
<th>K0739/E1340</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI</td>
<td>13.41</td>
<td>VT*</td>
<td>14.40</td>
</tr>
<tr>
<td>MN</td>
<td>13.41</td>
<td>WA*</td>
<td>21.37</td>
</tr>
<tr>
<td>MO</td>
<td>13.41</td>
<td>WI</td>
<td>13.41</td>
</tr>
<tr>
<td>MS</td>
<td>13.41</td>
<td>WV</td>
<td>13.41</td>
</tr>
<tr>
<td>WY*</td>
<td>18.70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In 2009, code K0739 was established in the HCPCS file to replace code E1340 for Medicare claims for the repair of beneficiary-owned DME with dates of service on or after April 1, 2009, (see Transmittal 443, CR 6296 issued on February 13, 2009, which may be reviewed at http://www.cms.hhs.gov/transmittals/downloads/R443OTN.pdf on the CMS Web site). The 2009 allowed payment amounts for code E1340 mapped directly to code K0739.

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

For complete details regarding this CR please see the official instruction (CR 6511) issued to your Medicare MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1754CP.pdf on the CMS Web site.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008—CR 6509 RESCINDS AND FULLY REPLACES CR 6404
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: MM6509
Related Change Request (CR) #: 6509
Related CR Release Date: May 22, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R497OTN
Implementation Date: July 6, 2009

Provider Types Affected
Suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs), Medicare administrative contractors (MACs) and/or durable medical equipment Medicare administrative contractors (DME MACs)) for oxygen services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on replacement CR 6509 which provides additional instructions regarding maintenance and servicing of oxygen concentrators and transfilling equipment resulting from implementation of section 144(b) of the MIPPA. Earlier instructions pertaining to the MIPPA changes for oxygen equipment were issued as part of CRs 6297 (Transmittal 421) and 6296 (Transmittal 443) and the MLN Matters® articles for these CRs are available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf, respectively, on the CMS Web site.
Background
Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36 month payment cap. Section 144(b) of MIPPA mandates payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap. The 36-month cap applies to stationary and portable oxygen equipment furnished on or after January 1, 2006; therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006.

CMS has determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made no more often than every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases), and the allowed payment amount for each visit is equal to the 2009 fee for code K0739, multiplied by 2, for the state in which the in-home visit takes place.

In the case of all oxygen equipment furnished after the 36-month rental cap, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime of the equipment. This includes parts that must be replaced in order for the supplier-owned equipment to continue to function appropriately. Payment shall not be made for any repairs or maintenance and servicing, other than the maintenance and servicing payments described above, of oxygen equipment. Suppliers may not charge beneficiaries for any repairs, parts or servicing of equipment that they are required to furnish for the remainder of the equipment’s reasonable useful lifetime.

Key Points
• Medicare contractors will pay claims with dates of service from July 1, 2009, thru December 31, 2009, for maintenance and servicing for oxygen concentrators no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use when billed with one of the following HCPCS codes and modifiers:
  ▪ E1390MS;
  ▪ E1391MS; or
  ▪ E1392MS.
• In addition to payment for maintenance and servicing for stationary oxygen concentrators (HCPCS codes E1390 or E1391) Medicare contractors will pay claims with dates of service from July 1, 2009, thru December 31, 2009, for maintenance and servicing for portable oxygen transfilling equipment (HCPCS code K0738) no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use. HCPCS code K0738 must be billed with the HCPCS modifier “MS” to obtain such payment.
• Medicare contractors will not pay for maintenance and servicing of both a portable oxygen concentrator (E1392MS) and portable oxygen transfilling equipment (K0738MS).
• If maintenance and servicing is billed for a column I code in the following table, additional payment for the maintenance and servicing of any of the column II codes should not be made as in the following example:
For the oxygen equipment codes E1390, E1391, E1392, and K0738, billed with the modifier “MS”, Medicare contractors will make maintenance and servicing payments for covered services equal to the lesser of the supplier’s actual charge or 2 units of K0739 every 6 months.

Medicare contractors will deny claims for maintenance and servicing of oxygen equipment when billed with the HCPCS codes E0424, E0439, E0431, E0434, E1405 or E1406 and the “MS” modifier.

Program instructions will be issued in the future regarding the continuation of the maintenance and servicing payments for dates of service on or after January 1, 2010.

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

The official instruction, CR 6509, issued to your Medicare DME MAC, MAC and/or RHHI regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R497OTN.pdf on the CMS website.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008—Rescinded
The Centers for Medicare & Medicaid Services (CMS) has rescinded the Special Edition (SE) Medicare Learning Network (MLN) Matters article entitled, “Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008,” which was published in the May 1, 2009, Home Health & Hospice Medicare A Newsline. This article was rescinded on May 27, 2009, and replaced by article number MM6509, which is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6509.pdf on the CMS Web site. The article was rescinded because CR 6404 was rescinded and replaced by CR 6509.

MLN Matters Number: MM6404 Rescinded
Related CR Release Date: March 20, 2009
Related CR Transmittal #: R461OTN
Related Change Request (CR) #: 6404
Effective Date: July 1, 2009
Implementation Date: July 6, 2009
**July Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)**

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: [http://www.cms.hhs.gov/MLNMattersArticles](http://www.cms.hhs.gov/MLNMattersArticles)

**MLN Matters® Number:** MM6484  
**Related Change Request (CR) #:** 6484  
**Related CR Release Date:** May 29, 2009  
**Related CR Transmittal #:** R1748CP  
**Effective Date:** January 1, 2009

**Provider Types Affected**  
Physicians, non-physician practitioners and providers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

**Provider Action Needed**  
This article is based on CR 6484, which amends payment files that were issued to Medicare contractors based on the 2009 MPFS Final Rule. Be sure billing staff are aware of the Current Procedure Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) changes made in this July update to the 2009 MPFSDB.

Payment files were issued to contractors based upon the 2009 MPFS Final Rule. CR 6484 amends those payment files. Changes included in the July Update to the 2009 MPFSDB are as follows:

**The following changes are effective for dates of service on and after January 1, 2009:**

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>50593</td>
<td>Bilateral indicator = 1</td>
</tr>
<tr>
<td>77421 Global</td>
<td>Physician Supervision Diagnostic Indicator = 09</td>
</tr>
<tr>
<td>77421 TC</td>
<td>Physician Supervision Diagnostic Indicator = 02</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>ACTION</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>92025 Global</td>
<td>Bilateral Indicator = 2</td>
</tr>
<tr>
<td>92025 TC</td>
<td>Bilateral Indicator = 2</td>
</tr>
<tr>
<td>92025 26</td>
<td>Bilateral Indicator = 2</td>
</tr>
</tbody>
</table>

**Note:** Changes to CPT code 93351 were included in the April update to the MPFSDB. Fully implemented facility practice expense relative value units (PE RVUs) were inadvertently not listed in Attachment 1 of the April update but were included on the payment files. Below are the fully implemented facility PE RVUs for CPT code 93351. This service is typically not paid under the Medicare physician fee schedule when provided in a facility setting and the fully implemented facility PE RVUs listed below are informational only.

93351 Global - Fully Implemented Facility PE RVU: 5.07
93351 TC - Fully Implemented Facility PE RVU: 4.15
93351 26 - Fully Implemented Facility PE RVU: 0.92

**The following changes are effective for dates of service on and after July 1, 2009:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 90670 | Long Descriptor: Pneumococcal conjugate vaccine, 13 valent, for intramuscular use  
Short descriptor: Pneumococcal vacc, 13 val im  
Procedure Status: X |
| 92507 | PC/TC Indicator = 7 |
| 92508 | PC/TC Indicator = 7 |
| 92526 | PC/TC Indicator = 7 |
| 92597 | PC/TC Indicator = 7 |
| 92607 | PC/TC Indicator = 7 |
| 92608 | PC/TC Indicator = 7 |
| 92609 | PC/TC Indicator = 7 |
| 96125 | PC/TC Indicator = 7 |
| 0199T | Long descriptor: Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report  
Short descriptor: Physiologic tremor record  
Procedure Status: C |
| 0200T | Long descriptor: Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles  
Short descriptor: Perq sacral augmt unilat inj  
Procedure Status: C |
| 0201T | Long descriptor: Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles  
Short descriptor: Perq sacral augmt bilat inj  
Procedure Status: C |
0202T  Long descriptor: Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine
   Short descriptor: Post vert arthrplst 1 lumbar
   Procedure Status: C

Q2023  Long descriptor: Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.
   Short descriptor: Xyntha, inj
   Procedure Status: E

Q4115  Long descriptor: Skin substitute, alloskin, per square centimeter
   Short descriptor: Alloskin skin sub
   Procedure Status: E

Q4116  Long descriptor: Skin substitute, alloderm, per square centimeter
   Short descriptor: Alloderm skin sub
   Procedure Status: E

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

The official instruction, CR 6484, issued to your Medicare carrier, FI and/or MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1748CP.pdf on the CMS Web site.

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New Drug/Biological Health Care Procedure Code System (HCPCS) Codes for July 2009 Update
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: MM6477
Related Change Request (CR) #: 6477
MLN Matters® Number: MM6477
Related CR Release Date: June 5, 2009
Effective Date: July 1, 2009, except as noted in article
Related CR Transmittal #: R1752CP
Implementation Date: July 6, 2009

Home Health & Hospice  July 1, 2009
Medicare A Newsline  Vol. 16, No. 10
Provider Types Affected
Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal
intermediaries (FIs), regional home health intermediaries (RHHIs)), Medicare administrative contractors
(MACs), and durable medical equipment Medicare administrative contractors (DME MACs) for drugs and
biologicals provided to Medicare beneficiaries.

Provider Action Needed
This article explains updates, effective for dates of service on or after July 1, 2009, (unless otherwise
specified), to HCPCS codes for certain drugs and biologicals. Ensure that your staffs are aware of these
changes.

Background
The HCPCS code set is updated on a quarterly basis. This article describes updates for specific
drug/biological HCPCS codes. Effective for claims with dates of service on or after July 1, 2009, the
following HCPCS codes will be payable for Medicare:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
<th>TOS Code</th>
<th>MPFSDB* Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2023</td>
<td>Xyntha, inj</td>
<td>INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA), PER I.U.</td>
<td>1 E</td>
<td></td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin skin sub</td>
<td>SKIN SUBSTITUTE, ALLOSKIN, PER SQUARE CENTIMETER</td>
<td>1 E</td>
<td></td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm skin sub</td>
<td>SKIN SUBSTITUTE, ALLODERM, PER SQUARE CENTIMETER</td>
<td>1 E</td>
<td></td>
</tr>
</tbody>
</table>

* MPFSDB – Medicare Physician Fee Schedule Data Base

The Medicare Coverage Indicator for the following codes was incorrectly listed on the January 2009,
HCPCS code set file. With the July 2009 quarterly update to the HCPCS code set, we are correcting the file
to show a Medicare Coverage Indicator of the letter “D”. The letter “D” indicates that “special coverage
instructions apply” and the applicable special coverage instructions are provided in the local coverage
determinations (LCD) regarding inhalation drugs. These updates are based on CR 5981 and are effective
for claims with dates of service on or after April 1, 2008. Note that Medicare contractors will not search for
and adjust claims processed before this change is implemented. However, they will adjust such claims that
you bring to their attention.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Medicare Coverage Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7611</td>
<td>Albuterol non-comp con</td>
<td>D</td>
</tr>
<tr>
<td>J7612</td>
<td>Levalbuterol non-comp con</td>
<td>D</td>
</tr>
<tr>
<td>J7613</td>
<td>Albuterol non-comp unit</td>
<td>D</td>
</tr>
<tr>
<td>J7614</td>
<td>Levalbuterol non-comp unit</td>
<td>D</td>
</tr>
</tbody>
</table>

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone
Us” to call the Provider Contact Center.
The official instruction, CR 6477, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding
this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1752CP.pdf on the CMS
Web site.

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contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a
general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the
specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

The ICD-10 Clinical Modification/Procedure Coding System (CM/PCS)—The Next
Generation of Coding—Revised
The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Special Edition (SE)
Medicare Learning Network (MLN) Matters article entitled, “The ICD-10 Clinical Modification/Procedure
Coding System (CM/PCS)—The Next Generation of Coding,” which was published in the November 1,
2008, Home Health & Hospice Medicare A Newsline. This MLN Matters article and other CMS articles can
be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: SE0832 Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: This article was revised on May 14 and May 19, 2009, to modify the diagnosis code example,
procedure code example, and the description of the ICD-10-CM diagnoses codes under the
“Structural Differences Between the Two Coding Systems” heading and also to modify a Web address
to link to the ICD-10 Final Rule. All other information remains the same.

Provider Types Affected
This article is informational only for all physicians, providers, and suppliers who submit claims to Medicare
contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment
Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health
intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This Special Edition article (SE0832) outlines general information for providers detailing the International
Classification of Diseases, 10th Edition (ICD-10) classification system. Compared to the current ICD-9
classification system, ICD-10 offers more detailed information and the ability to expand specificity and
clinical information in order to capture advancements in clinical medicine. Providers may want to become
familiar with the new coding system.

The system is not yet implemented in Medicare’s fee-for-service (FFS) claims processes so no action is
needed at this time.
Background
A number of other countries already use ICD-10, including:

- United Kingdom (1995);
- France (1997);
- Australia (1998);
- Germany (2000); and
- Canada (2001).

ICD-10-CM/PCS consists of two parts:

- ICD-10-CM – The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM); and
- ICD-10-PCS – The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

ICD-10-CM/PCS:

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services;
  - Increased sensitivity when refining grouping and reimbursement methodologies;
  - Enhanced ability to conduct public health surveillance; and
  - Decreased need to include supporting documentation with claims.
- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.
- Provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and
  - Conducting research.

Structural Differences Between the Two Coding Systems

1. Diagnoses Codes
ICD-9-CM diagnoses codes are 3 – 5 digits in length with the first digit being alpha (E or V) or numeric and digits 2 – 5 being numeric. For example:

- 496 – Chronic airway obstruction not elsewhere classified (NEC);
- 511.9 – Unspecified pleural effusion; and
- V02.61 – Hepatitis B carrier.
ICD-10-CM diagnoses are 3 – 7 digits in length with the first digit being alpha, digit 2 being numeric and digits 3 – 7 are alpha or numeric. The alpha digits are not case sensitive. For example:

- A78 - Q fever;
- A69.21 – Meningitis due to Lyme disease; and
- S52.131a – Dislocated fracture of neck of right radius, initial encounter for closed fracture.

2. Procedure Codes

ICD-9-CM procedures are 3 – 4 digits in length and all digits are numeric. For example:

- 43.5 – Partial gastrectomy with anastomosis to esophagus; and
- 44.42 – Suture of duodenal ulcer site.

ICD-10-PCS procedures are 7 digits in length with each of the 7 digits being either alpha or numeric. The alpha digits are not case sensitive. Letters O and I are not used to avoid confusion with the numbers 0 and 1. For example:

- 0FB03ZX – Excision of Liver, Percutaneous Approach, Diagnostic; and
- 0DQ10ZZ – Repair upper esophagus, open approach.

Note that ICD-10-CM/PCS would not affect physicians, outpatient facilities, and hospital outpatient departments’ usage of Current Procedural Terminology (CPT) codes on Medicare FFS claims as CPT use would continue.

Additional Information

The CMS has developed a dedicated Web page for ICD-10 information. That page is at http://www.cms.hhs.gov/ICD10 on the CMS Web site.

Details on the ICD-10-PCS Coding System, mappings, and a related training manual may be found at http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage on the CMS Web site.


Details on the ICD-10-CM Coding system, mappings, and guidelines may be found at http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm on the Internet and also at http://www.cms.hhs.gov/ICD10/03_2008_ICD_10_CM.asp#TopOfPage on the CMS Web site.

Many private sector professional organizations and businesses have resources available that may help with ICD-10-CM/PCS implementation planning.

Please note that the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act (HIPAA) standard. The dedicated CMS ICD-10 page also has links to these resources in the “Related Links Outside of CMS” at the bottom of the page.
Influenza Pandemic Emergency -- The Medicare Program Prepares—Revised
The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Special Edition (SE) Medicare Learning Network (MLN) Matters article entitled, “Influenza Pandemic Emergency -- The Medicare Program Prepares,” which was published in the January 1, 2009, Home Health & Hospice Medicare A Newsline. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

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 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 on the CMS Web site. 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/R404OTN.pdf on the CMS Web site;
- CR 6164, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf on the CMS Web site;
- CR 6174, which can be found at http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf on the CMS Web site;
- CR 6209, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R411OTN.pdf on the CMS Web site;
- CR 6256, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R428OTN.pdf on the CMS Web site;
- CR 6280, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R441OTN.pdf on the CMS Web site;
- CR6284, which is at http://www.cms.hhs.gov/Transmittals/downloads/R439OTN.pdf; and

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Discontinuance of the Unique Physician Identification Number (UPIN) Registry—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Medicare Learning Network (MLN) Matters article entitled, “Discontinuance of the Unique Physician Identification Number (UPIN) Registry,” which was published in the November 1, 2007, Home Health & Hospice Medicare A Newsline. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles
Note: This article was revised on June 1, 2009, to remove the Web link to the UPIN registry, which is no
longer maintained, and also to remove another link to the NPI contingency plan that no longer works as the
information is no longer available on the Internet.

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

Provider Action Needed
STOP – Impact to You
This article is based on CR 5584, which announces that CMS will discontinue assigning Unique Physician
Identification Numbers (UPINs) on June 29, 2007.

CAUTION – What You Need to Know
The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and
Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy
identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers
for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and
surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further
notice.)

GO – What You Need to Do
If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and
free by going to the National Plan and Provider Enumeration System (NPPES) Web site at
https://nppes.cms.hhs.gov/ on the CMS Web site. See the “Background” and “Additional Information”
sections of this article for further details.

Background
CMS was required by law to establish an identifier that could be used in Medicare claims to uniquely
identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to
physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns
UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the
Medicare program. Medicare claims for services that were ordered for services that resulted from referrals
must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the
Secretary adopted a standard unique health identifier to identify health care providers in transactions for
which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the
National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in
HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered
entities (health plans, health care clearinghouses, and those health care providers who transmit any data
electronically in connection with a HIPAA standard transaction) are required by that regulation to begin
using NPIs in these transactions no later than May 23, 2007, (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007, implementation by Medicare.

The CMS discontinued assigning UPINs on June 29, 2007. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Additional Information
For additional information regarding NPI requirements and use, please see MLN Matters articles, MM4023 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf) titled, “Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms”, and MM4293 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf) titled, “Revised CMS-1500 Claim Form”, which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR 5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf on the CMS Web site.

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

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Revised Implementation Date for Change Request 6426
The Centers for Medicare & Medicaid Services (CMS) has announced a delay in the implementation date of Change Request (CR) 6426, “Instructions on Utilizing 837 Institutional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part A Claims.” The implementation date first issued for CR 6426 was July 6, 2009. As a result of the delay, the implementation date is now scheduled for October 5, 2009. For additional information, refer to the Medicare Learning Network (MLN) Matters article, MM6426, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf
FDA Consumer Alert: Warning Consumers of a Tainted Skin Sanitizer

Following an announcement by the U. S. Food and Drug Administration (FDA) warning consumers of a tainted skin sanitizer, the Centers for Medicare & Medicaid Services (CMS) is advising health care providers and consumers not to use skin products made by Clarcon Biological Chemistry Laboratory. Clarcon is voluntarily recalling some skin sanitizers and skin protectants marketed under several different brand names because of high levels of disease-causing bacteria found in the product during a recent inspection.

Consumers and providers are being warned to not use any Clarcon products and to throw these products away in household refuse.

FDA analyses of several samples of Clarcon products revealed high levels of various bacteria, including some associated with unsanitary conditions. Some of these bacteria can cause opportunistic infections of the skin and underlying tissues. Such infections may need medical or surgical attention, and may result in permanent damage. Examples of products that should be discarded include:

- Citrushield Lotion
- Dermasentials DermaBarrier
- Dermassentials by Clarcon Antimicrobial Hand Sanitizer
- Iron Fist Barrier Hand Treatment
- Skin Shield Restaurant
- Skin Shield Industrial
- Skin Shield Beauty Salon Lotion
- Total Skin Care Beauty
- Total Skin Care Work

Health care professionals and consumers may report serious adverse events (side effects) or product quality problems with the use of this product to the FDA's MedWatch Adverse Event Reporting program either online, by regular mail, fax or phone.

-- Online https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm
-- Regular Mail: use postage-paid FDA form 3500 http://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm and mail to MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787
-- Fax: 800-FDA-0178
-- Phone: 800-FDA-1088

For more information: http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm164845.htm
July 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: MM6492 Related Change Request (CR) #: 6492
Related CR Release Date: May 22, 2009 Effective Date: July 1, 2009
Related CR Transmittal #: R107BP and R1745CP Implementation Date: July 6, 2009

Provider Types Affected
Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and which are paid under the OPPS.

Provider Action Needed
This article is based on CR 6492 which describes changes to and billing instructions for various payment policies implemented in the July 2009 OPPS update. Be sure billing staffs are aware of these changes.

Background
CR 6492 describes changes to and billing instructions for various payment policies implemented in the July 2009 OPPS update and it affects the Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 1, §50.3; Ch. 4, §§10 and 290; and Ch. 17, § 90.3. It also updates the Medicare Benefits Policy Manual (CMS Pub. 100-02), Ch. 6, §20.6, to clarify the existing policy.

July 2009 revisions to the Integrated Outpatient Code Editor (I/OCE) data files, instructions, and specifications are provided in CR 6480 (July 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.2).” Upon release of CR 6480 a related MLN Matters article will be available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6480.pdf on the CMS Web site.

Key OPPS Updates for July 2009
1. Changes to Procedure and Device Edits for July 2009

Procedure to device edits require that when a particular procedural Healthcare Common Procedure Coding System (HCPCS) code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site.
2. Outlier Reconciliation
CMS updated the Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 4, §10.7.2, to more explicitly identify distinctions between the OPPS outlier reconciliation policy and those of other payment systems. CMS made changes to note that the OPPS outlier reconciliation criteria use OPPS specific-information, specifically 1) the Cost-to-Charge Ratio (CCR) is the OPPS CCR used to make OPPS outlier payments and 2) total outlier payments are total OPPS outlier payments. These changes clarify the manual language to eliminate confusion that the OPPS reconciliation might consider Inpatient Prospective Payment System (IPPS) or other payment system CCRs or total outlier payments across payment systems.

3. Updated Pricer Logic for Certain Blood Products
The January 2009 OPPS Pricer contained a programming error that may result in the underpayment or overpayment of certain blood products that are eligible for the blood deductible when billed together on the same claim. The whole blood and packed red cells described by the following HCPCS codes are eligible for the blood deductible:

<table>
<thead>
<tr>
<th>HCPCS Codes Eligible for the Blood Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9010</td>
</tr>
<tr>
<td>P9016</td>
</tr>
<tr>
<td>P9021</td>
</tr>
</tbody>
</table>

The blood deductible is applied to these products only when the hospital incurs a charge for the blood product itself, in addition to a charge for processing and storage. The January 2009 OPPS Pricer programming error affects only those claims on which more than one of the blood product HCPCS codes listed above appears, when at least one of those codes is not subject to the blood deductible because the hospital did not incur a charge for the blood product itself.

Specifically, an underpayment or overpayment may occur when the following conditions are met:

1) More than one blood product that is eligible for the blood deductible (i.e., whole blood and packed red cells) appears on the claim;

2) At least one of the blood products appearing on the claim that is eligible for the blood deductible is not subject to the blood deductible due to the absence of payment adjustment flag (PAF) 5 and 6 indicating the hospital incurred a charge for the blood itself (the Integrated Outpatient Code Editor applies PAF 5 or 6 to blood lines eligible for the blood deductible when the hospital reports charges for the blood product itself using revenue code series 038X (excluding 0380) in addition to charges for processing and storage services using revenue code 0390, 0392, or 0399);

3) The dates of service fall on or after January 1, 2009, but prior to July 1, 2009; and

4) The claim was processed for payment prior to the installation of the July 2009 OPPS Pricer on July 6, 2009.

This programming error has been corrected in the July 2009 OPPS Pricer. Providers who think they may have received an incorrect payment as a result of this programming error may voluntarily submit claims to their contractors for repayment following the implementation of the July 2009 OPPS Pricer on July 6, 2009.
4. Category III CPT Codes

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567; see http://www.gpoaccess.gov/fr/retrieve.html on the Internet), CMS modified their process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by us in response to applications for new technology services. Therefore, on July 1, 2009, CMS will implement in the OPPS four Category III CPT codes that the AMA released in January 2009 for implementation in July 2009. The codes, along with their status indicators and Ambulatory Payment Classifications (APCs), are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2009 OPPS Update that is posted at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site.

Table 1--Category III CPT Codes Implemented as of July 1, 2009

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0199T</td>
<td>Physiologic recording of tremor using accelerometer(s) and gyroscope(s),</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(including frequency and amplitude) including interpretation and report</td>
<td>0215</td>
<td>S</td>
</tr>
<tr>
<td>0200T</td>
<td>Percutaneous sacral augmentation (sacroplasty), unilateral injection(s),</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>including the use of a balloon or mechanical device (if utilized), one or more</td>
<td>0049</td>
<td>T</td>
</tr>
<tr>
<td></td>
<td>needles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0201T</td>
<td>Percutaneous sacral augmentation (sacroplasty), bilateral injections,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>including the use of a balloon or mechanical device (if utilized), two or</td>
<td>0050</td>
<td>T</td>
</tr>
<tr>
<td></td>
<td>more needles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0202T</td>
<td>Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>including facetectomy, laminectomy, foraminotomy and vertebral column fixation,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with or without injection of bone cement, including fluoroscopy,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>single level, lumbar spine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

Unless otherwise specified in the long description, HCPCS code descriptors refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.
a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2009

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

In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2009 release of the OPPS PRICER. The updated payment rates, effective July 1 2009, will be included in the July 2009 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2009

Nine drugs and biologicals have been granted OPPS pass-through status effective July 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9250*</td>
<td>Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml</td>
<td>9250</td>
<td>G</td>
</tr>
<tr>
<td>C9251*</td>
<td>Injection, C1 esterase inhibitor (human), 10 units</td>
<td>9251</td>
<td>G</td>
</tr>
<tr>
<td>C9252*</td>
<td>Injection, plerixafor, 1 mg</td>
<td>9252</td>
<td>G</td>
</tr>
<tr>
<td>C9253*</td>
<td>Injection, temozolomide, 1 mg</td>
<td>9253</td>
<td>G</td>
</tr>
<tr>
<td>C9360*</td>
<td>Dermal substitute, native, non-denatured collagen, neonatal bovine origin</td>
<td>9360</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>(SurgiMend Collagen Matrix), per 0.5 square centimeters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C9361*</td>
<td>Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length</td>
<td>9361</td>
<td>G</td>
</tr>
<tr>
<td>C9362*</td>
<td>Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc</td>
<td>9362</td>
<td>G</td>
</tr>
<tr>
<td>C9363*</td>
<td>Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter</td>
<td>9363</td>
<td>G</td>
</tr>
<tr>
<td>C9364*</td>
<td>Porcine implant, Permacol, per square centimeter</td>
<td>9364</td>
<td>G</td>
</tr>
</tbody>
</table>

**NOTE:** The HCPCS codes identified with an “*” indicate that these are new codes effective July 1, 2009.
c. New HCPCS Codes Effective for Certain Drugs and Biologicals
Three new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting for July 2009. These codes are listed in Table 3 below and are effective for services furnished on or after July 1, 2009.

**Table 3- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2009**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2023</td>
<td>Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.</td>
<td>1268</td>
<td>K</td>
</tr>
<tr>
<td>Q4115</td>
<td>Skin substitute, alloskin, per square centimeter</td>
<td>1269</td>
<td>K</td>
</tr>
<tr>
<td>Q4116</td>
<td>Skin substitute, alloderm, per square centimeter</td>
<td>1270</td>
<td>K</td>
</tr>
</tbody>
</table>

d. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009, through March 31, 2009
The payment rates for several HCPCS codes were incorrect in the January 2009 OPPS PRICER. The corrected payment rates are listed in Table 4 below and have been installed in the July 2009 OPPS PRICER, effective for services furnished on January 1, 2009, through implementation of the April 2009 update. If you have claims that were processed prior to April 1, 2009, with these codes for services on or after January 1, 2009, but prior to April 1, 2009, you may ask your Medicare contractor to adjust the claims.

**Table 4-Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 Through March 31, 2009**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1441</td>
<td>K</td>
<td>7049</td>
<td>Filgrastim 480 mcg injection</td>
<td>$304.27</td>
<td>$60.85</td>
</tr>
<tr>
<td>J1740</td>
<td>K</td>
<td>9229</td>
<td>Ibandronate sodium injection</td>
<td>$136.35</td>
<td>$27.27</td>
</tr>
<tr>
<td>J2505</td>
<td>K</td>
<td>9119</td>
<td>Injection, pegfilgrastim 6mg</td>
<td>$2,135.12</td>
<td>$427.02</td>
</tr>
<tr>
<td>J47513</td>
<td>K</td>
<td>1612</td>
<td>Daclizumab, parenteral</td>
<td>$341.09</td>
<td>$68.22</td>
</tr>
</tbody>
</table>

e. Recognition of Multiple HCPCS Codes For Drugs
Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a status indicator “B” indicating that another code existed for OPPS purposes. For example, if drug X has 2 HCPCS codes, one for a 1 ml dose and a second for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and status indicator “B” to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPPS. However, beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.
f. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

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

g. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS code descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS code descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. The HCPCS code short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

h. Unit Correction – HCPCS code J9181, Etoposide, 10 mg

Table 5 ‘HCPCS Code Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008’ listed in Transmittal 1657, Change Request (CR) 6320, issued December 31, 2008, incorrectly listed the number of units in the long code descriptor for HCPCS code J9181, Etoposide, 10 mg. HCPCS code J9181 which is assigned status indicator ‘N’ in CY 2009 under the OPPS, is the code for 10 mg of Etoposide, while HCPCS code J9182 was discontinued effective January 1, 2009. Providers may review the short and long HCPCS code descriptors in the HCPCS file that is available at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ on the CMS Web site.

6. Clarification Related to the Appropriate Use of HCPCS Code C9399

CMS revised the Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 17, §90.3, to clarify the appropriate use of HCPCS code C9399. Specifically, HCPCS code C9399 should be used by hospitals when billing a new drug or biological that has been approved by the FDA on or after January 1, 2004, and for which a product-specific HCPCS code has not been assigned. Beginning on or after the date of FDA approval, hospitals may bill for the drug or biological using C9399, Unclassified drug or biological.
Hospitals will report in the ANSI ASC X-12 837 I in specific locations, or in the “Remarks” section of the CMS 1450:

- The National Drug Code (NDC);
- The quantity of the drug that was administered (expressed in the unit of measure applicable to the drug or biological); and
- The date the drug was furnished to the beneficiary.

Medicare contractors will manually price the drug or biological at 95 percent of the Average Wholesale Price (AWP). They will pay hospitals 80 percent of the calculated price and will bill beneficiaries 20 percent of the calculated price, after the deductible is met. Drugs and biological that are manually priced at 95 percent of AWP are not eligible for outlier payment.


Nuclear medicine procedure-to-radiolabeled product edits require that when a nuclear medicine procedure HCPCS code is billed, the claim must also contain an appropriate radiolabeled product. Failure to pass these edits will result in the claim being returned to the provider. Nuclear medicine procedure-to-radiolabeled product edits require that a claim that contains one of a specified set of nuclear medicine codes be returned to the provider if it fails to contain an appropriate radiolabeled product code. The updated lists of both types of edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site.

8. Clarification Related to Observation Services

CMS updated the Medicare Claims Processing Manual (CMS Pub 100-04), Ch. 4, §290, and the Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 6, §20.6, to clarify that a hospital begins billing for observation services, reported with HCPCS code G0378, at the clock time documented in the patient’s medical record, which coincides with the time that observation services are initiated in accordance with a physician’s order for observation services. Editorial changes to the manuals remove references to “admission” and “observation status” in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term “admission” is typically used to denote an inpatient admission and inpatient hospital services. For payment purposes, there is no payment status called “observation”. Observation care is an outpatient service, ordered by a physician and reported with a HCPCS code.

9. Clarification Related to Condition Code 44

The changes to the Medicare Claims Processing Manual (CMS Pub 100-04), Ch. 1, §50.3, incorporate information and guidance published in MLN Matters article SE0622, published March, 2006, which you can review at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf on the CMS Web site. MLN Matters article SE0622 provided clarification to Transmittal 299, CR 3444, issued September 10, 2004. You can also review the revised Chapter 1 (§50.3) of the Medicare Claims Processing Manual (CMS Pub. 100-04), which is included as an attachment to CR 6492, which is at http://www.cms.hhs.gov/Transmittals/downloads/downloads/R1745CP.pdf on the CMS Web site.

10. Coverage Determinations

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

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Accreditation Requirements—Revised
The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Special Edition (SE) Medicare Learning Network (MLN) Matters article entitled, “Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Accreditation,” which was published in the May 1, 2009, Home Health & Hospice Medicare A Newsline. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.hhs.gov/MLNMattersArticles

MLN Matters® Number: SE0903 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: March 1, 2009
Implementation Date: N/A

Note: This article was revised on May 20, 2009, to provide important information for suppliers who choose not to become accredited.

Provider Types Affected
All suppliers that furnish Medicare Part B durable medical equipment (DME), prosthetic devices, prosthetic or orthotic items, and supplies to Medicare beneficiaries.

Provider Action Needed
STOP – Impact to You
DMEPOS suppliers enrolled with the National Supplier Clearinghouse (NSC) are required to obtain accreditation by September 30, 2009.

CAUTION – What You Need to Know if You Choose Not to Become Accredited
In order to obtain or retain your Medicare Part B billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health and
Human Services as noted below in this article) must comply with the Medicare program’s supplier standards and quality standards and become accredited. These standards can be found in 42 CFR 424.57 or on page 36 & 37 of the CMS 855S. A DMEPOS supplier’s Medicare Part B billing privileges will be revoked on or after **October 1, 2009**, if the DMEPOS supplier fails to obtain accreditation unless the DMEPOS supplier submits a voluntary termination to the NSC by **September 30, 2009**.

**GO – What You Need to Do if You Choose Not to Become Accredited**

For those DMEPOS suppliers who choose not to become accredited at this time, they will need to submit an amended CMS-855S application which reflects their voluntary termination. This will prevent the supplier from being revoked and subsequently barred from the Medicare program, as cited in 42 CFR Section 424.535(c). For pharmacies that choose not to become accredited but wish to remain a DMEPOS supplier in order to continue to bill Medicare for drugs and biologicals only, an amended CMS 855S will have to be completed. In addition to updating their application, the supplier must ensure that they have checked the appropriate boxes in Section 2 (C) to reflect which drugs and biologicals they will provide to beneficiaries. Providers and suppliers can find the latest version of CMS 855S at [http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf) on the CMS Web site.

**Background**

Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a) (20) to the Social Security Act (the Act) that required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to obtain or retain their provider or supplier billing privileges.

**Covered Items and Services**

Pursuant to subparagraph 1834(a) (20) (D) of the Act, the covered items and services are defined in Section 1834 (a) (13), Section 1834 (h) (4) and Section 1842 (s) (2) of the Act. The covered items and services include:

- Durable medical equipment (DME);
- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Blood products;
- Transfusion medicine;
- Prosthetic devices, and
- Prosthetics and orthotics.

**Non-Covered Items include:**

- Medical supplies furnished by home health agencies;
- Drugs used with DME (inhalation drugs and drugs infused with a DME pump);
- Implantable items and;
- Other Part B drugs:
  - Immunosuppressive drugs; and
  - Anti-emetic drugs.
DMEPOS Quality Standards
The quality standards are published at
http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf on
the CMS Web site, are separated into two sections and have three appendices as follows:

- **Section I** includes the business standards that apply to all suppliers and focus on standards for
  administration, financial management, human resource management, consumer services, performance
  management, product safety and information management.
- **Section II** contains service standards, including intake, delivery and setup, training and instruction of
  the beneficiary and/or their caregiver and follow-up service.
- **Appendix A** addresses respiratory equipment, supplies and services.
- **Appendix B** addresses manual wheelchairs and power mobility devices, including complex
  rehabilitation and assistive technology.
- **Appendix C** addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast
  prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic,
  ocular and facial prostheses.

Accreditation Deadline for DMEPOS Suppliers
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) set a deadline for all
DMEPOS suppliers to be accredited by September 30, 2009.

Who Needs Accreditation?
The September 30, 2009, accreditation deadline applies to all suppliers of durable medical equipment,
medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition,
transfusion medicine and prosthetic devices, prosthetics and orthotics that are enrolled with the NSC. The
accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic
fitters/technicians and athletic trainers.

Who is Exempt?
The eligible professionals that are exempt from the September 30, 2009, accreditation deadline include the
following practitioners:
- Physicians (as defined in Section 1861(r) of the Act);
- Physician Assistants;
- Nurse Practitioners;
- Physical Therapists;
- Occupational Therapists;
- Speech-Language Pathologists;
- Clinical Nurse Specialists;
- Certified Registered Nurse Anesthetists;
- Certified Nurse-Midwives;
- Clinical Social Workers;
- Clinical Psychologists;
- Registered Dietitians; and
- Nutritional professionals.
Additionally MIPPA allows the Secretary to specify “other persons” that are exempt from meeting the September 30, 2009, accreditation deadline unless the Secretary determines that the quality standards are specifically designed to apply to such other persons. At this time, these “other persons” are only defined as the following practitioners:

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists.

Key Points
All Medicare Part B enrolled DMEPOS providers and suppliers are required to obtain accreditation by September 30, 2009.

DMEPOS suppliers who submitted a completed application to an accrediting organization on or before January 31, 2009, will have their accreditation decision (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization after January 31, 2009, may or may not have their accreditation decision by the September 30, 2009, deadline.

A DMEPOS supplier’s Medicare Part B billing privileges will be revoked on or after October 1, 2009, if the DMEPOS supplier fails to obtain accreditation or a voluntary termination has not been received by the NSC by September 30, 2009. If a supplier chooses not to become accredited, they must submit an amended CMS 855S to prevent revocation and subsequent exclusion from the Medicare program.

Accreditation Frequently Asked Questions (FAQs)

1. **Do the accrediting organizations have enough capacity to get everyone who applies at least 9 months before September 30, 2009, accredited by the deadline?**

   Yes. The AOs have increased surveyor staffing anticipating the additional workload. A DMEPOS supplier should choose an AO based upon their deemed status, policies, procedures and the philosophy of the organization. CMS encourages suppliers to ask the AOs questions, such as, how long it takes to become accredited from application to accreditation decision. The time to become accredited can take up to 9 months for some organizations.

2. **Who are the approved DMEPOS accrediting organizations?**

   In November 2006, CMS approved (deemed) 10 national accreditation organizations that will accredit providers and suppliers of DMEPOS as meeting new quality standards under Medicare Part B. Most of the accreditation organizations are authorized to accredit all major supplier types, and most will be able to accredit both national and local suppliers, as well as mail order companies. A list of the CMS approved deemed accreditation organizations and information about the types of suppliers each accrediting organization is approved to accredit and how to contact a deemed accrediting organization is posted at: [http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf](http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf) on the CMS Web site.
3. **Is accreditation transferable upon merger, acquisition or sale of a supplier?**

Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57 (c) (3), CMS, the NSC and the accrediting organization must be notified when a new DMEPOS location is opened.

4. **If I have just recently received a survey by an accreditor, will I be subject to a site visit by a representative of the National Supplier Clearinghouse (NSC)?**

These actions are independent of one another. The accreditor checks quality standards. The NSC site visit concerns enforcing supplier standards. In many cases a new supplier will receive a site survey by the AO and a site visit by the NSC.

5. **Is information transferred between the accreditor and NSC?**

Transfer of information between these two entities concerning their findings does occur.

6. **Will the accreditation survey efforts be coordinated with reenrollment efforts?**

Not at the present time. A supplier must meet both the NSC supplier standards and the accreditation requirements on a continuous basis. We are not changing reenrollment dates and timeframes to match survey timeframes.

**Additional Information**

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” to call the Provider Contact Center. There is additional information on the accreditation process at [http://www.cms.hhs.gov/MedicareProviderSupEnroll/DMEPOS_DeemedAccreditationOrganizations.asp](http://www.cms.hhs.gov/MedicareProviderSupEnroll/DMEPOS_DeemedAccreditationOrganizations.asp) on the CMS Web site.

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**News from Cahaba for Home Health and Hospice Providers**

**Updated Frequently Asked Questions (FAQs) for Top Inquiries**

Based on a review of the topics most asked during April through June 2009, the Frequently Asked Questions (FAQs) for the top inquiries received in Cahaba's Home Health & Hospice Provider Call Center (PCC) have been updated. Providers should attempt to resolve their Medicare questions using the FAQs and "Resources for the Most Common Medicare Part A Provider Questions" Web page ([http://www.cahabagba.com/rhhi/claims/provider_resources.htm](http://www.cahabagba.com/rhhi/claims/provider_resources.htm)) prior to calling the Customer Service
Representatives (CSRs). Please ensure that your staff is aware that Cahaba CSRs should be contacted only to answer questions that cannot be resolved through self-service options such as the FAQs, “Resources” Web page and other materials posted to the Cahaba Web site, the Interactive Voice Response (IVR) system, the Cahaba ListServ, and Internet based educational offerings.

The updated FAQs can be accessed on our Web site using the following link: http://www.cahabagba.com/rhhi/faqs/index.htm

Providers without Internet access may request a copy of the FAQs by calling the Provider Outreach and Education department at 515-471-7335.

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

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

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list).

We encourage you to bookmark the Quarterly Provider Update Web site and visit it often for this valuable information.

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Telephone Us” to call the Provider Contact Center.
Medicare Credit Balance Quarterly Reminder
This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **July 30, 2009**, for the quarter ending **June 30, 2009**.

The **Medicare Credit Balance Report (CMS-838)** and certification must be postmarked by the date indicated above. If the information is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

To ensure timely receipt and processing, please send the report to the following address:

<table>
<thead>
<tr>
<th>If sending overnight:</th>
<th>If sending overnight:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attention: Credit Balance, Sta. 210</strong></td>
<td><strong>Attention: Credit Balance, Sta. 210</strong></td>
</tr>
<tr>
<td>Provider Audit and Reimbursement</td>
<td>Provider Audit and Reimbursement</td>
</tr>
<tr>
<td>Cahaba GBA</td>
<td>Cahaba GBA</td>
</tr>
<tr>
<td>P.O. Box 14537</td>
<td>400 E Court Ave</td>
</tr>
<tr>
<td>Des Moines, IA  50306-3537</td>
<td>Des Moines, IA  50309-2019</td>
</tr>
</tbody>
</table>

If you have any questions, or if you need a paper copy of the CMS-838 form, please contact the Medicare Credit Balance telephone line at **515-471-7444**.

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**System Availability During the July 4th Holiday**
While we celebrate the July 4th holiday with our families, our offices will be closed on Friday, July 3, 2009. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) will not be available on July 3rd. Access to the eligibility screens, ELGA/ELGH will not be available Friday, July 3 and Saturday, July 4th. In addition, the system will not cycle on July 3rd, which means that claims will not be sent to the Common Working File (CWF) on July 3, 2009. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced July 3, 2009.
Availability of the Provider Contact Center (PCC)
Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). Listed below is the date and time the home health and hospice PCC (1-877-299-4500 and 1-866-539-5592) will be closed for training. We will continue to notify you of future CSR training dates in the *Home Health & Hospice Medicare A Newsline*.

<table>
<thead>
<tr>
<th>CSR Training Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 23, 2009</td>
<td>1:15—3:45 p.m. Central Time (CT)</td>
</tr>
</tbody>
</table>

News from Cahaba for Home Health Providers

Using the Appropriate Form to Request Assistance with a Transfer Dispute
When requesting Cahaba’s assistance with a home health transfer dispute, please make sure that you are using the appropriate form. The current “Notification of Disputed HHA Transfer” form was updated in May 2009, and is available on Cahaba’s Web site. Recently, we have received many transfer dispute requests from home health agencies using incorrect or outdated forms. Discard any old forms you have and ensure you are using the updated form.

In addition, Cahaba encourages home health providers to review the information found on the “Transfer Dispute Between HHAs” and “Beneficiary Elected Home Health Transfer” Web pages prior to requesting assistance to ensure all agency responsibilities and documentation requirements have been met.

Venipuncture… “Is that covered?”
We have recently seen an increase in questions and requests for clarification of the coverage guidelines regarding venipuncture for patients under a home health plan of care. The Balanced Budget Act, effective February 5, 1998, stated that venipuncture for the purposes of obtaining a blood sample could no longer be the sole reason for Medicare home health eligibility. This is only true if venipuncture is the qualifying skill. However, if a beneficiary qualifies for home health based on another skilled need such as therapy, or other nursing needs, then venipuncture may be a billable skilled service.
The venipuncture must be medically necessary, like all services, for Medicare to pay. The Medicare Benefit Policy Manual, (CMS Pub. 100-02), Ch. 7, §40.1.2.13, discusses when venipuncture is reasonable and necessary:

1. The physician order for the venipuncture for a laboratory test should be associated with a specific symptom or diagnosis, or the documentation should clarify the need for the test when it is not diagnosis/illness specific. In addition, the treatment must be recognized (in the Physician’s Desk Reference, or other authoritative source) as being reasonable and necessary to the treatment of the illness or injury for venipuncture and monitoring the treatment must also be reasonable and necessary.

2. The frequency of testing should be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even where the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.

Again, when the venipuncture is medically necessary and there is another skilled service that qualifies the beneficiary for the Medicare home health benefit, Medicare may pay the skilled nurse visit to perform the venipuncture.

EXAMPLE: A patient with coronary artery disease was hospitalized with atrial fibrillation and for a fractured femur. Subsequently, the patient was discharged to the home health agency with orders for new anticoagulation therapy and physical therapy needs. The qualifying skilled needs for this patient are the physical therapy and the observation/assessment and teaching by the skilled nurse. Venipunctures, as indicated, are necessary to report PT/INR levels to the physician for titration of the anticoagulant therapy. These visits are billable, because there are already other qualifying skilled services in the home.

Widespread Probe Notification for Home Health Providers—Length of Stay Greater Than 999 Days

As a result of data analysis, Cahaba will soon be conducting a widespread review on home health claims. This edit is set to select home health claims with a length of stay greater than 999 days. The topic code for this review will be 5008W. Claims will be selected across the provider community billing these services that meet the parameters of the edit. Once selected, the claims will be reviewed for medical necessity (e.g., compliance with CMS guidelines, contractor local coverage determinations (LCDs), correct billing and coding). Once completed, the results of this probe will be posted in the “News” section of our Web site.
July and August 2009 Education Events

To register for educational events, go to the “Calendar of Educational Events” page on our Web site. Select the event title for registration instructions.

- **“FISS 501: The Big Picture” Webinar**
  - **Date:** July 7, 2009
  - **Time:** 12:00 – 2:00 p.m. Central Time
  - **Registration Deadline:** July 1, 2009
  - **Intended Audience:** Home health and hospice provider staff, including administrators and billers.
  - **Description:** This Webinar will focus on how claims process through the Fiscal Intermediary Standard System (FISS), including the various edits that affect claim processing. The relationship between the Common Working File (CWF) and FISS, and the impact to claims processing, will also be discussed.

- **“Iowa Home Health Clinicians: Outstanding in Our Field” Teleconference**
  - **Date:** July 23, 2009
  - **Time:** 12:00 – 1:30 p.m. Central Time
  - **Registration Deadline:** July 17, 2009
  - **Intended Audience:** Home health clinicians, administrators, QI coordinators.
  - **Description:** This teleconference is being sponsored by the Iowa Alliance for Home Care. It will cover Iowa’s top Medical Review denials in 2009, and how to avoid them. Information about making good coverage decisions and documentation of homebound, skilled nursing, therapies, and medical social worker will also be provided.
  - **Register:** To register, contact the Iowa Alliance for Home Care online at [www.iowahomecare.org](http://www.iowahomecare.org) or by phone at 515-282-3965.

- **“Navigating the Medicare Resources Sea” Webinar**
  - **Date:** July 28, 2009
  - **Time:** 12:00 – 2:00 p.m. Central Time
  - **Registration Deadline:** July 23, 2009
  - **Intended Audience:** Home health and hospice provider staff who have less than 25 full-time employees, or who are new or have staff new to Medicare.
  - **Description:** This Webinar will explore Medicare resources for home health and hospice providers found on the Cahaba and the Centers for Medicare & Medicaid Services (CMS) Web sites, including the self-service technologies available.
“Hospice Clinicians: Looking Back and Ahead in Medical Review” Webinar
Date: July 30, 2009
Time: 10:00 – 11:30 a.m. Central Time
Registration Deadline: July 27, 2009
Intended Audience: Hospice clinicians, administrators, QI coordinators.
Description: This Webinar will cover the top Medical Review denials, thus far, in 2009, and how to avoid them. The nuances of terminal prognosis, and capturing symptoms in documentation will also be discussed.

“Hospice Billing – Part 1” Webinar
Date: August 4, 2009
Time: 12:00 (noon) – 2:00 p.m. Central Time
Registration Deadline: July 30, 2009
Intended Audience: New hospice providers or hospices with staff that are new to hospice billing, and small hospice agencies with 25 or fewer full-time employees.
Description: This Webinar will provide basic education on billing a hospice notice of election (NOE) and claim, eligibility requirements, levels of care, and billing of physician services. Information about common hospice billing errors and resources to assist hospice billers will also be presented.

“Home Health Billing – Part 1” Webinar
Date: August 11, 2009
Time: 12:00 (noon) – 2:00 p.m. Central Time
Registration Deadline: August 6, 2009
Intended Audience: New home health providers or home health agencies with staff that are new to hospice billing, and small hospice agencies with 25 or fewer full-time employees.
Description: This webinar will cover the requirements necessary to be eligible for Medicare coverage of home health services, and the information needed to bill a typical home health Request for Anticipated Payment (RAP) and final claim. We will also identify and discuss common home health billing errors, and offer resources to help avoid those errors, as well as how to appropriately submit non-routine supplies (NRS) to Medicare.
“Hospice Billing – Part 2” Webinar
Date: August 18, 2009
Time: 12:00 (noon) – 2:00 p.m. Central Time
Registration Deadline: August 13, 2009
Intended Audience: New hospice providers or hospices with staff that are new to hospice billing, and small hospice agencies with 25 or fewer full-time employees.
Description: This Webinar will present how and when to submit a cancel NOE, how to cancel a benefit period, appropriate billing of discharge/revocation claims, including the posting of revocations when omitted, and billing in transfer situations. In addition, the use of the advance beneficiary notice (ABN) will also be discussed as well as various billing situations and top billing errors and available resources.

“Home Health Billing – Part 2” Webinar
Date: August 25, 2009
Time: 12:00 (noon) – 2:00 p.m. Central Time
Registration Deadline: August 20, 2009
Intended Audience: New home health (HH) providers or HH agencies with staff that are new to HH billing, and small HH agencies with 25 or fewer full-time employees.
Description: This Webinar will cover appropriately submitting claims for special home health billing situations, including beneficiary transfers between home health agencies, and discharge/readmission during the same episode of care; avoiding billing errors for overlapping episodes and dates of service; and much more. An overview of common home health billing errors and resources for avoiding them will also be presented.

“Online Courses” are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

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<thead>
<tr>
<th>Course Title</th>
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<tbody>
<tr>
<td>Adjusting and Canceling Claims</td>
<td>Learn how to adjust or cancel claims.</td>
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<tr>
<td>Advanced Hospice Billing</td>
<td>Learn about advanced hospice billing topics.</td>
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<tr>
<td>Appeals Process</td>
<td>Learn about the Medicare appeals process.</td>
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“Online Courses” (Continued)

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</tr>
<tr>
<td>Beginner Home Health Billing</td>
<td>Learn the basics of home health billing.</td>
</tr>
<tr>
<td>CERT (Comprehensive Error Rate Test)</td>
<td>Learn about the CERT Program.</td>
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<tr>
<td>Checking Claims Status</td>
<td>Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.</td>
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<tr>
<td>Comprehending Medicare Claims Processing</td>
<td>Learn about Medicare claims processing.</td>
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<tr>
<td>Medicare Coding (Insight into)</td>
<td>Learn the basics about Medicare coding.</td>
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<tr>
<td>Medicare Cost Report (Introduction to)</td>
<td>Learn the basics about the Medicare Cost Report</td>
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<tr>
<td>Medical Review (Getting a view of)</td>
<td>Learn the basics of the Medical review process.</td>
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<tr>
<td>Medicare Secondary Payer</td>
<td>Learn the basics of Medicare Secondary Payer.</td>
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<tr>
<td>Overview of Medicare</td>
<td>Learn the basics about the Medicare program.</td>
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<td>Provider Enrollment</td>
<td>Learn about provider enrollment and how to apply.</td>
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<tr>
<td>Verifying Beneficiary Eligibility</td>
<td>Learn how to identify various eligibility information by using ELGA and ELGH.</td>
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Please note these courses were designed specifically for providers served by Cahaba. You can find additional national courses under the Medicare Learning Network.

Didn’t find what you were looking for? Visit our Web site—it provides a variety of valuable information and is continuously updated.

Stay Informed! Subscribe to the Cahaba E-mail Notification Service to receive the most current home health and hospice Medicare information. This service is free. When you subscribe, we’ll send you periodic e-mails telling you about new or updated information that has been added to our Web site. Your e-mail address will not be shared with other subscribers or given to advertisers, and once subscribed, you can unsubscribe from the list, or change your e-mail address at any time.