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

Important Information from Cahaba Government Benefit Administrators®, LLC (Cahaba)

October 1, 2009 Vol. 17, No. 1

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

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News Flash Messages from CMS for Home Health and Hospice Providers

ICD-10-CM/PCS Medicare Learning Network Products
The Medicare Learning Network (MLN) product, ICD-10-CM/PCS Myths & Facts (June 2009), which presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in print format. To place your order, visit http://www.cms.hhs.gov/MLNGenInfo/, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page”.

Also available is the ICD-10-CM-PCS Bookmark (revised August 2009), which provides information about the ICD-10-Clinical Modification/Procedure Coding System including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system can be found. The bookmark is now available in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10ClinModBookmrk.pdf on the CMS Web site.
HIPAA Versions 5010 and D.0 Conference Call Information Available

On June 9, 2009, the Centers for Medicare & Medicaid Services (CMS) conducted a national provider conference call on the HIPAA Versions 5010 and D.0. You can view the presentation, transcript and listen to the audio file from that call by accessing [http://www.cms.hhs.gov/Versions5010andD0/Downloads/6-9-2009_National_Provider_Call.pdf](http://www.cms.hhs.gov/Versions5010andD0/Downloads/6-9-2009_National_Provider_Call.pdf) on the CMS Web site.

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Flu Season Is Upon Us!

Begin now to take advantage of each health care visit as an opportunity to encourage your patients to get a flu shot. It’s still their best defense against combating the flu this season. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don’t forget, health care personnel can spread the highly contagious flu virus to patients. **Protect yourself. Don’t Get the Flu. Don’t Give the Flu. Get Your Flu Shot.**

**Remember** - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare’s coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals, please go to [http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf](http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf) on the CMS Web site.

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News from CMS for Home Health and Hospice Providers

Medicare Fee-for-Service (MFFS) Billing for the Administration of the Influenza A (H1N1) Virus Vaccine

The Centers for Medicare & Medicaid Services (CMS) has provided the following Special Edition (SE) 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:** SE0920  
**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

**Provider Types Affected**

Physicians, providers, and suppliers administering the H1N1 vaccine to Medicare patients are affected by this article.
Provider Action Needed
This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine. All providers administering this vaccine should review this article and be sure that their billing staffs are aware of this information.

Note from Cahaba: A hospice can provide vaccines to any beneficiary who requests it, including beneficiaries who have elected the hospice benefit. However, hospices bill and are reimbursed for these vaccines under Medicare Part B by the Part B carrier/Part A/B Medicare administrative contractor (A/B MAC). Hospices that do not have supplier billing number(s) should contact their local Part B carrier/A/B MAC to obtain one. Once you obtain a supplier billing number, submit services for vaccines to your local Medicare Part B carrier/A/B MAC for payment.

Background
Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be a medical necessity. The Influenza A (H1N1) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the administration of the H1N1 vaccine.

CMS has created two new HCPCS codes for H1N1, effective for dates of service on and after September 1, 2009:

- G9141—Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)
- G9142—Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 0771. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. Since the H1N1 vaccine will be made available at no cost to providers, Medicare will not pay providers for the vaccine. Providers do not need to place the G9142 (H1N1 vaccine code) on the claim. However, if the G9142 appears on the claim, only the claim line will be denied.

Payment will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Providers who normally participate in the Medicare Part B program as mass immunizer roster billers and mass immunizer centralized billers may submit H1N1 administration claims using the roster billing format. The same information must be captured for the H1N1 roster claims as it is for the seasonal influenza roster claims. The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Control number for Medicare contractor;
- Patient's health insurance claim number;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary’s signature or stamped “signature on file”.

For this upcoming flu season, Medicare will reimburse Medicare beneficiaries, up to the fee schedule amount, for the administration of H1N1 influenza vaccine when furnished by a provider not enrolled in Medicare. Beneficiaries must submit a Form CMS-1490S to their local Medicare contractor. Medicare will reimburse beneficiaries for the administration of the H1N1 vaccine, but not the H1N1 vaccine itself because the H1N1 vaccine will be furnished at no cost to all providers. Medicare beneficiaries may not be charged any amount for the H1N1 vaccine itself.

Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. We understand that such preparations are critical for the upcoming flu season, especially in planning for the influenza A (H1N1) vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e. the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A (H1N1) vaccination, then Medicare will pay for both. However, as noted earlier, please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine’s administration (not for the vaccine itself).

Note from Cahaba: Home health agencies (HHAs) receive reimbursement for administering flu shots under the Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) code 0350 that is assigned to HCPCS code G0008. This payment methodology will also be applied to the reimbursement that HHAs receive for the administration of the H1N1 vaccine for HCPCS G9141. The reimbursement amount is adjusted for the geographic area where the flu shot was provided and other factors. The reimbursement for APC code 0350 for calendar year (CY) 2009 is $24.89. Due to the adjustments under OPPS, the actual payment amount your HHA receives could be more or less than this amount. Cahaba is unable to provide the actual amount you will receive for the flu shot administration since this is based on OPPS processing. In addition, we encourage HHAs to submit their flu shots to Medicare electronically using the roster bill screen available in the Fiscal Intermediary Standard System (FISS), whenever possible. More information about accessing and using this screen is available in the “Claims and Attachments” section of the FISS Reference Guide. Additional information on billing home health vaccination claims can be found on the “Roster Billing and Mass Influenza and Pneumococcal Pneumonia Vaccines” and “Billing Individual Influenza and Pneumococcal Pneumonia Vaccines” Web pages. Please be aware that charges for the seasonal flu vaccination and an influenza A (H1N1) vaccination should be submitted to Medicare on separate roster bills.

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.
You may also want to review the following MLN Matters® articles:

- MM6626 (October 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)) at [http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6626.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6626.pdf); and


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October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3
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)

<table>
<thead>
<tr>
<th>MLN Matters® Number: MM6618</th>
<th>Related Change Request (CR) #: 6618</th>
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<tbody>
<tr>
<td>Related CR Release Date: August 28, 2009</td>
<td>Effective Date: October 1, 2009</td>
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<tr>
<td>Related CR Transmittal #: R1809CP</td>
<td>Implementation Date: October 5, 2009</td>
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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 6618, which notifies providers that the I/OCE Specifications Version 10.3 is effective October 1, 2009. Be sure billing staffs are aware of these changes.

Background
CR 6618 describes changes to billing instructions for various payment policies implemented in the October 2009 OPPS update. The October 2009 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR 6618. Attached to CR 6618 are lengthy specifications for the I/OCE. A summary of the changes for October 2009 is within Appendix M of Attachment A of CR 6618 and that summary is captured in the following key points.

Key Points of CR 6618
- The program will assign Payment Adjustment Flag #4 (Deductible not applicable) to all lines on any OPPS claim where condition code “MA” is present on the claim. This modification was effective January 1, 2003.
2. Modifier 77 will be added to the list of modifiers that will bypass edit 17 – Inappropriate specification of bilateral procedure. This modification was effective January 1, 2003.

3. If code G0379 has been denied or rejected, it will not be included in any subsequent special direct admission logic. The default SI (Q3) will be retained as the final SI. An exception is if line item adjustment flag (LIAF) = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent direct admission logic and that logic will determine the final SI). This modification was effective January 1, 2008.

4. STVX/T-packaged codes (Q1, Q2) that are denied or rejected will not be included in any subsequent special packaging logic. The default SI (Q1, Q2) will be retained as the final SI. An exception is if LIAF = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent special packaging logic and that logic will determine the final SI). This modification was effective January 1, 2008.

5. For codes with SI of S, T, V or X that have been denied or rejected, those codes will be ignored in subsequent special S, T, V, X/T logic for packaging Q1 or Q2 codes. An exception is if LIAF = 1 has been assigned to the line, the denial/rejection will be ignored and the line will be included in subsequent logic for packaging the Q1 or Q2 codes. This modification is effective October 1, 2009.

6. For Multiple Imaging composite processing, any independently bilateral composite candidate with modifier 50 will count as 2 units in applying the composite criteria. If any composite Ambulatory Payment Classification (APC) is assigned on an independent or conditional bilateral line with modifier 50 the modifier will be ignored in assigning the discount formula. This modification was effective January 1, 2009.

7. Any T-packaged (Q/Q2) independent or conditional bilateral code with modifier 50 that is paid separately will have the modifier ignored in assigning the discount formula. This modification was effective January 1, 2008.

8. Any STVX-packaged (Q/Q1) independent or conditional bilateral code with modifier 50 that is paid separately will have the modifier ignored in assigning the discount formula. This modification was effective January 1, 2007.

9. Medicare has made numerous changes to diagnosis codes, APCs, HCPCS/CPT codes and modifiers. Those changes can be found in the Attachment to CR 6618 that is titled “Preliminary Summary of Data Changes Integrated OCE v 10.3 Effective October 1, 2009”.

10. Version 15.2 of the National Correct Coding Initiatives will be implemented effective with the October 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 6618) issued to your Medicare MAC and/or FI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1809CP.pdf on the CMS Web site.

CMS also has a Web-based training module on the OCE. The module is available at http://cms.meridianksi.com/kc/main/kc_frame.asp?ke_ident=kc0001&loc=1 on the Internet.

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Claim Status Category Code and Claim Status Code 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: MM6609  Related Change Request (CR) #: 6609
Related CR Release Date: August 14, 2009  Effective Date: October 1, 2009
Related CR Transmittal #: R1797CP  Implementation Date: October 5, 2009

Provider Types Affected
All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, A/B Medicare administrative contractors (MACs) and durable medical equipment MACs (DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed
This article, based on CR 6609, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the June 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on the Internet on or about June 30, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

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, CR6609, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1797CP.pdf on the CMS Web site.

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October 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

MLN Matters® Number: MM6585 Related Change Request (CR) #: 6585
Related CR Release Date: August 14, 2009 Effective Date: October 1, 2009
Related CR Transmittal #: R1795CP Implementation Date: October 5, 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.

Provider Action Needed
This article is based on CR 6585 and instructs Medicare contractors to download and implement the October 2009 ASP drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised July 2009, April 2009, January 2009, and October 2008, files. Medicare will use the October 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 October 5, 2009, with dates of service October 1, 2009, through December 31, 2009. See the “Background” and “Additional Information” sections of this article for further details regarding these changes.

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

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 Outpatient Prospective Payment System (OPPS).

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5 percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4 percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent 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) Chapter 17, §20.1.3 and may be reviewed at http://www.cms.hhs.gov/manuals/downloads/clin04c17.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>Files</th>
<th>Effective Dates of Service</th>
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<tbody>
<tr>
<td>October 2009 ASP and ASP NOC files</td>
<td>October 1, 2009, through December 31, 2009</td>
</tr>
<tr>
<td>July 2009 ASP and ASP NOC files</td>
<td>July 1, 2009, through September 30, 2009</td>
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<tr>
<td>April 2009 ASP and ASP NOC files</td>
<td>April 1, 2009, through June 30, 2009</td>
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<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 shall make these determinations.

**Additional Information**
The official instruction (CR 6585) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1795CP.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.

CMS would like providers to be aware that the following MLN products are available through the MLN Catalogue:
- The guide at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf describes topics such as: types of Remittance Advice (RA), the purpose of the RA and types of codes that appear on the RA.

3. The brochure at http://www.cms.hhs.gov/MLNProducts/downloads/Protectingpracbroch508-09.pdf highlights some of the steps providers can employ to protect their practices from inappropriate Medicare business interactions.

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Medicare Parts A and B Coverage and Prior Authorization
The Centers for Medicare & Medicaid Services (CMS) has provided the following Special Edition (SE) 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: SE0916
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Provider Action Needed
This article is based on the Social Security Act and other laws which describe covered and non-covered items and services and their payment under Part A and Part B. Originally, the Social Security Act did not authorize any form of “prior authorization” for Medicare services. The law was subsequently changed to allow prior authorization of limited items of Durable Medical Equipment and physicians’ services. Currently, Medicare does not pre-authorize coverage of any item or service that will receive payment under Part A or B, except for custom wheelchairs. Please advise all staff and inform your Medicare patients, as appropriate, that Medicare does not currently pre-authorize coverage for any item or service other than custom wheelchairs.

Background
The overall scope of allowable benefits under the Medicare program is prescribed by law. When Medicare was established, Congress included certain provisions on the broad categories of items and services that may be covered under the Medicare program as well as provisions on certain items and services that were to be excluded from coverage. Congress also included in Section 1862(a)(1)(A) of the Social Security Act the following provision:
"Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,..."

This clause has become known as the “reasonable and necessary” provision. Medicare coverage and payment for items and services is therefore contingent upon a determination that an item and service:

- Falls within a benefit category;
- Is not specifically excluded from coverage; AND
- The item or service is “reasonable and necessary” unless specifically excluded from meeting this provision.

Also, as prescribed by law, CMS develops National Coverage Determinations (NCDs), which are national policy statements granting, limiting, or excluding Medicare coverage for a particular item or service. NCDs may be found in the Medicare National Coverage Determinations Manual (CMS Pub. 100-03) at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site.

For those items or services whose coverage is not determined in law, regulation or NCD, the local Medicare contractors are authorized to develop local coverage determinations (LCDs) to further determine coverage of items and services covered by Medicare. LCDs specify under what conditions an item or service is considered to be “reasonable and necessary”. Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, including comments from the provider community. LCDs may be found on the CMS coverage Web site and your local contractor’s Web site.

If a provider believes that a Medicare NCD or LCD needs to be revised, they should request CMS or its contractors to reconsider the existing NCD or LCD. What factors CMS considers when deciding to open or reopen an NCD can be found at https://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=6 on the CMS Web site. To request a new LCD or an LCD reconsideration, the provider should contact the local Medicare contractor.

In regard to prior authorization under fee-for-service Medicare, providers should be aware that section 1834(a)(15)(c) of the Social Security Act allows for an Advance Determination of Medicare Coverage (ADMC) for certain items of Durable Medical Equipment (DME). The only items of DME currently subject to this provision are custom wheelchairs. Also, Section 938 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173) required the Secretary to establish a “Prior Determination” process for a limited number of physicians’ services under Medicare. Implementation of this provision is pending. It should also be noted that Medicare Part C & Part D programs are authorized to have and may require prior authorizations for services billed to them.

**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
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Enhancements/Updates to NPPES Effective On/After September 13, 2009
System maintenance has been performed to the National Plan and Provider Enumeration System (NPPES). The following security enhancements were incorporated into NPPES, effective September 13, 2009:

- **NPPES web users will be required to select five secret questions and answers.** Upon implementation of this enhancement and upon successful login, NPPES web users will be prompted to select five secret questions and provide answers to those questions. These five secret questions and answers will be saved and used for verification in order to allow NPPES web users to reset their own passwords.

- **NPPES web users will be prevented from changing their passwords more than once within 24 hours from the last password update.** Upon implementation of this enhancement, NPPES web users will be required to wait 24 hours before attempting to change their passwords once they have already successfully reset their passwords.

Electronic File Interchange (EFI)
In addition, the EFI User Manual and Technical Companion Guide have been revised. The upcoming changes will not impact the EFI XML Schema.

Additional Information
Health care providers can apply for an NPI online at https://nppes.cms.hhs.gov. Health care providers needing assistance with applying for an NPI or updating their data in NPPES records may contact the NPI Enumerator at 1-800-465-3203 or email the request to the NPI Enumerator at: CustomerService@NPIEnumerator.com

Not sure if you have already obtained an NPI or cannot remember your NPI, you can visit the NPI Registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do to search for the information. The NPI Registry enables you to search for a provider’s NPPES information, which includes the NPI. All information displayed in the NPI Registry is done so in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Name/Legal Business Name. There is no charge to use the NPI Registry.

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.

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Addition/Deletion of HCPCS Codes – October 2009 Quarterly 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](http://www.cms.hhs.gov/MLNMattersArticles)

<table>
<thead>
<tr>
<th>MLN Matters® Number:</th>
<th>MM6594</th>
<th>Related Change Request (CR) #:</th>
<th>6594</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date:</td>
<td>August 28, 2009</td>
<td>Effective Date:</td>
<td>October 1, 2009</td>
</tr>
<tr>
<td>Related CR Transmittal #:</td>
<td>R1805CP</td>
<td>Implementation Date:</td>
<td>October 5, 2009</td>
</tr>
</tbody>
</table>
Provider Types Affected
Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MACs), regional home health intermediaries (RHHIs), and durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article explains updates, effective for dates of service on or after October 1, 2009, (unless otherwise specified), to the Healthcare Common Procedure Coding System (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 HCPCS codes and the October 2009 update has only one new code payable for Medicare. Effective for claims with dates of service on or after October 1, 2009, the following HCPCS code will be payable for Medicare:

- HCPCS Code Q2024 with short description of Bevacizumab injection and long description of INJECTION, BEVACIZUMAB, 0.25 MG, a Type of Service Code 1 or P and a Medicare Physician Fee Schedule Data Base Status Indicator of E.

There are no deletions of HCPCS codes effective for October 1, 2009.

Additional 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.

The official instruction, CR 6594, issued to your Medicare carrier, FI, RHHI, DME MAC and/or MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1805CP.pdf on the CMS Web site.

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Influenza Pandemic Emergency -- The Medicare Program Prepares—Rescinded
The Centers for Medicare & Medicaid Services (CMS) has rescinded the following Medicare Learning Network (MLN) Matters article entitled, “Influenza Pandemic Emergency -- The Medicare Program Prepares—Revised,” 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
MLN Matters Number: SE0836 Rescinded  
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: The Centers for Medicare & Medicaid Services rescinded this article on September 11, 2009.

Disclaimer
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**News from CMS for Home Health Providers**

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**October 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](http://www.cms.hhs.gov/MLNMattersArticles)

MLN Matters® Number: MM6626  
Related Change Request (CR) #: 6626
Related CR Release Date: August 28, 2008  
Effective Date: October 1, 2009
Related CR Transmittal #: R1803CP  
Implementation Date: October 5, 2009

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

**Provider Action Needed STOP – Impact to You**
This article is based on CR 6626 which describes changes to and billing instructions for various payment policies implemented in the October 2009 OPPS update.

**CAUTION – What You Need to Know**
The October 2009 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions for October. Those revisions to the I/OCE data files, instructions, and specifications are provided in CR 6618, “October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3.” The MLN article related to CR 6618 is included in this Newsline issue (above article), and is also available at [http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6618.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6618.pdf) on the CMS Web site.
GO – What You Need to Do
See the “Background” and “Additional Information” sections of this article for further details regarding these changes.

Key Points of CR 6626

Changes to Procedure and Device Edits for October 2009
Procedures to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the Web site.

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.

For 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.

• Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2009
For calendar year (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 is suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated 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 October 2009 release of the OPPS
Pricer. The updated payment rates, effective October 1, 2009, will be included in the October 2009 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp on the CMS Web site.

- **New HCPCS Code Effective for Certain Drugs and Biologicals**
  A new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for October 2009. HCPCS code Q2024 is listed in Table 1 below and is effective for services furnished on or after October 1, 2009. This HCPCS code is assigned status indicator “K,” to indicate separate payment may be made for the product.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 10/1/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2024</td>
<td>Injection, Bevacizumab, 0.25 mg</td>
<td>1281</td>
<td>K</td>
</tr>
</tbody>
</table>

- **Adjustment to Status Indicator for HCPCS code Q4115 Effective October 1, 2009**
  CMS assigned HCPCS code Q4115, Skin substitute, alloskin, per square centimeter, a status indicator of “M” for services billed on or after July 1, 2009, through September 30, 2009, indicating that the service is not billable to the FI/MAC. For services furnished on or after October 1, 2009, CMS is changing the status indicator for Q4115 to “K” to indicate that separate payment may be made for this product. HCPCS code Q4115 is assigned to Ambulatory Payment Classification (APC) 1287 (Alloskin skin sub).

- **Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008, through June 30, 2008**
  The payment rates for several HCPCS codes were incorrect in the April 2008 OPPS Pricer. The corrected payment rates are listed in Table 2 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on April 1, 2008, through implementation of the July 2008 update. If you have claims for these HCPCS codes for dates of service of April 1, 2008, through June 30, 2008, (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC’s attention, they will adjust such claims after the October 2009 OPPS Pricer is installed.

<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>J1440</td>
<td>K</td>
<td>0728</td>
<td>Filgrastim 300 mcg injection</td>
<td>$197.37</td>
<td>$39.47</td>
</tr>
<tr>
<td>J1441</td>
<td>K</td>
<td>7049</td>
<td>Filgrastim 480 mcg injection</td>
<td>$303.75</td>
<td>$60.75</td>
</tr>
<tr>
<td>J2505</td>
<td>K</td>
<td>9119</td>
<td>Injection, pegfilgrastim 6mg</td>
<td>$2,179.44</td>
<td>$435.89</td>
</tr>
<tr>
<td>J2788</td>
<td>K</td>
<td>9023</td>
<td>Rho d immune globulin 50 mcg</td>
<td>$26.06</td>
<td>$5.21</td>
</tr>
<tr>
<td>J2790</td>
<td>K</td>
<td>0884</td>
<td>Rho d immune globulin inj</td>
<td>$83.63</td>
<td>$16.73</td>
</tr>
<tr>
<td>J9050</td>
<td>K</td>
<td>0812</td>
<td>Carmus bischl nitro inj</td>
<td>$155.30</td>
<td>$31.06</td>
</tr>
</tbody>
</table>

- **Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008, through September 30, 2008**
  The payment rates for several HCPCS codes were incorrect in the July 2008 OPPS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on July 1, 2008, through implementation of the October 2008 update. If you
have claims for these HCPCS codes for dates of service of July 1, 2008, through September 30, 2008, (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC’s attention, they will adjust such claims after the October 2009 OPPS Pricer is installed.

Table 3 - Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

<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>J1438</td>
<td>K</td>
<td>1608</td>
<td>Etanercept injection</td>
<td>$172.44</td>
<td>$34.49</td>
</tr>
<tr>
<td>J1440</td>
<td>K</td>
<td>0728</td>
<td>Filgrastrim 300 mcg injection</td>
<td>$197.44</td>
<td>$39.49</td>
</tr>
<tr>
<td>J1626</td>
<td>K</td>
<td>0764</td>
<td>Granisetron HCl injection</td>
<td>$5.28</td>
<td>$1.06</td>
</tr>
<tr>
<td>J2505</td>
<td>K</td>
<td>9119</td>
<td>Injection, pegfilgrastim 6mg</td>
<td>$2,154.48</td>
<td>$430.90</td>
</tr>
<tr>
<td>J2788</td>
<td>K</td>
<td>9023</td>
<td>Rho d immune globulin 50 mcg</td>
<td>$26.70</td>
<td>$5.34</td>
</tr>
<tr>
<td>J2790</td>
<td>K</td>
<td>0884</td>
<td>Rho d immune globulin inj</td>
<td>$84.15</td>
<td>$16.83</td>
</tr>
<tr>
<td>J9208</td>
<td>K</td>
<td>0831</td>
<td>Ifosfomide injection</td>
<td>$34.10</td>
<td>$6.82</td>
</tr>
<tr>
<td>J9209</td>
<td>K</td>
<td>0732</td>
<td>Mesna injection</td>
<td>$7.86</td>
<td>$1.57</td>
</tr>
<tr>
<td>J9226</td>
<td>G</td>
<td>1142</td>
<td>Supprelin LA implant</td>
<td>$14,463.26</td>
<td>$2,865.36</td>
</tr>
</tbody>
</table>

• Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

The payment rates for several HCPCS codes were incorrect in the October 2008 OPPS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on October 1, 2008, through implementation of the January 2009 update. If you have claims for these HCPCS codes for dates of service of October 1, 2008, through December 31, 2008, (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC’s attention, they will adjust such claims after the October 2009 OPPS Pricer is installed.

Table 4 - Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

<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>Filgrastrim 480 mcg injection</td>
<td>$304.32</td>
<td>$60.86</td>
</tr>
<tr>
<td>J2505</td>
<td>K</td>
<td>9119</td>
<td>Injection, pegfilgrastim 6mg</td>
<td>$2,175.85</td>
<td>$435.17</td>
</tr>
<tr>
<td>J9209</td>
<td>K</td>
<td>0732</td>
<td>Mesna injection</td>
<td>$6.99</td>
<td>$1.40</td>
</tr>
<tr>
<td>J9226</td>
<td>G</td>
<td>1142</td>
<td>Supprelin LA implant</td>
<td>$14,413.33</td>
<td>$2,855.47</td>
</tr>
<tr>
<td>J9303</td>
<td>G</td>
<td>9235</td>
<td>Panitumumab injection</td>
<td>$81.86</td>
<td>$16.22</td>
</tr>
</tbody>
</table>

• Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

The payment rates for several HCPCS codes were incorrect in the July 2009 OPPS Pricer. The corrected payment rates are listed in Table 5 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on July 1, 2009, through implementation of the October 2009 update. If you have claims for these HCPCS codes for dates of service of July 1, 2009, through September 30, 2009, (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC’s attention, they will adjust such claims after the October 2009 OPPS Pricer is installed.
Table 5 - Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 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>90585</td>
<td>K</td>
<td>9137</td>
<td>Beg vaccine, percut</td>
<td>$115.47</td>
<td>$23.09</td>
</tr>
<tr>
<td>C9359</td>
<td>G</td>
<td>9359</td>
<td>Implant, bon void filler-putty</td>
<td>$65.21</td>
<td>$12.80</td>
</tr>
<tr>
<td>J9031</td>
<td>K</td>
<td>0809</td>
<td>Beg live intravesical vac</td>
<td>$114.73</td>
<td>$22.95</td>
</tr>
<tr>
<td>J9211</td>
<td>K</td>
<td>0832</td>
<td>Idarubicin hcl injection</td>
<td>$126.12</td>
<td>$25.22</td>
</tr>
<tr>
<td>J9265</td>
<td>K</td>
<td>0863</td>
<td>Paclitaxel injection</td>
<td>$7.62</td>
<td>$1.52</td>
</tr>
<tr>
<td>J9293</td>
<td>K</td>
<td>0864</td>
<td>Mitoxantrone hydrochl / 5 MG</td>
<td>$66.26</td>
<td>$13.25</td>
</tr>
<tr>
<td>Q0179</td>
<td>K</td>
<td>0769</td>
<td>Ondansetron hcl 8 mg oral</td>
<td>$7.91</td>
<td>$1.58</td>
</tr>
</tbody>
</table>

- **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.

- **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.

- **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.

- **Correct Reporting of Diagnostic Radiopharmaceuticals and their Associated Nuclear Medicine Procedures Furnished In Separate Calendar Years**

  There are certain rare instances when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year. As Medicare billing does not allow multiple calendar year services to be reported on a single claim, some hospitals have had difficulty reporting the radiolabeled product on the same claim as the nuclear medicine procedure when these associated services are not provided to the beneficiary in the same calendar year. Because of the nuclear medicine procedure-to-radiolabeled product claims processing edits included in the I/OCE, payment for a nuclear medicine procedure requires reporting of an appropriate radiolabeled product on the same claim. In this limited circumstance, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare, and CMS expects that the majority of hospitals will not encounter this situation.

- **H1N1 Vaccine and Administration Level II HCPCS Codes**

  In anticipation of the availability of a vaccine for the H1N1 virus in the fall of 2009, CMS is creating two new Level II HCPCS codes that are effective October 1, 2009. Similar to the influenza vaccine and its administration, one HCPCS code has been created to describe the H1N1 vaccine itself (G9142, Influenza A (H1N1) vaccine, any route of administration), while another HCPCS code has been created to describe the administration of the H1N1 vaccine (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)). More information on the H1N1 flu and the associated vaccine can be found at the Centers for Disease Control and Prevention website at [http://www.cdc.gov/h1n1flu](http://www.cdc.gov/h1n1flu) on the Internet.

  Under the OPPS, HCPCS code G9142 will be assigned status indicator “E,” indicating that payment will not be made by Medicare when this code is submitted on an outpatient bill type because CMS anticipates that the H1N1 vaccine will be supplied at no cost to providers. Payment will be made to a provider for the administration of the H1N1 vaccine, even if the vaccine is supplied at no cost to the provider. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPPS and non OPPS providers), and CMS is assigning HCPCS code G9141 to APC 0350 (Administration of Flu and PPV Vaccine) with a payment rate of $24.89 for CY 2009. Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

  The effective date of G9141 and G9142 is September 1, 2009. This effective date is earlier than originally anticipated, and therefore, the effective date reflected in the October I/OCE will be October 1, 2009. For the January I/OCE release, CMS will change the effective date for these HCPCS to be retroactive to September 1, 2009. Claims containing G9141 and G9142 with dates of service on or after September 1, 2009, but prior to October 1, 2009, will be held until the successful installation of the January I/OCE release.
**Updating Wage Indices for Hospitals Receiving Medicare Modernization Act (MMA) Section 508 Reclassification**

Table 6 of CR 6626 contains the October 1, 2009, to December 31, 2009, Wage Indexes for Section 508 hospitals that receive payment under the OPPS. This article will not repeat Table 6, but Section 508 hospitals may view the table in CR 6626 by going to [http://www.cms.hhs.gov/Transmittals/downloads/R1803CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R1803CP.pdf) on the CMS Web site.

**Clarification Related to Condition Code 44**

CR 6626 also makes changes to the *Medicare Claims Processing Manual*, (CMS Pub 100-04) Chapter 1, §50.3, incorporate minor revisions clarifying the use of Condition Code 44. The revised section of the manual is attached to CR 6626.

**Coverage Determinations**

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

**Additional Information**


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**

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**News from CMS for Hospice Providers**

**Heart**

**Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for Fiscal Year 2010**

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:** MM6606  
**Related Change Request (CR) #:** 6606  
**Related CR Release Date:** August 14, 2009  
**Effective Date:** October 1, 2009  
**Related CR Transmittal #:** R1796CP  
**Implementation Date:** October 5, 2009
Provider Types Affected
Hospice providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on CR 6606 which provides the annual update to the hospice payment rates for fiscal year (FY) 2010, the hospice aggregate cap amount for the cap period ending October 31, 2009, and the hospice wage index and Pricer for FY 2010. Be sure your billing staffs are aware of these changes, which are described in the “Background” section, below.

Background
CMS updates the payment for hospice care, the hospice aggregate cap amount, and the hospice wage index annually.

• The Social Security Act (Section 1814(i)(1)(C)(ii)) (the Act) stipulates that the payments for hospice care for FYs after 2002 will increase by the market basket percentage increase for that FY, and this payment methodology has been codified in the Code of Federal Regulations (Title 42, Section 418.306 (a)&(b)).


• The Hospice Aggregate Cap amount is updated annually. Specifically, the cap amount is increased or decreased for accounting years after 1984 by the same percentage as the percentage increase or decrease (respectively) in the medical care expenditure category of the Consumer Price Index for all Urban Consumers.

• The Hospice Wage Index, used to adjust payment rates to reflect local differences in wages according to the revised wage index, is updated annually in accordance with recommendations made by a negotiated rulemaking advisory committee as published in the Federal Register on August 8, 1997 (see http://bulk.resource.org/gpo.gov/register/1997/1997_42883.pdf on the Internet) and on August 8, 2008, (see http://edocket.access.gpo.gov/2008/pdf/E8-17795.pdf on the Internet); and the Code of Federal Regulations (42 CFR 418.306(c)) requires that the updated hospice wage index be published annually in the Federal Register (see http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr418.306.pdf on the Internet.)

The annual hospice payment updates will be implemented through the Hospice Pricer software. The new Pricer module will not contain any new calculation logic, but will simply apply the existing calculation to the updated payment rates shown below. An updated table will be installed in the module, to reflect the FY 2010 hospice wage index.

FY 2010 Hospice Payment Rates
The FY 2010 payment rates will be the FY 2009 payment rates, increased by 2.1 percentage points, which is the total hospital market basket percentage increase forecasted for FY 2010. The FY 2010 hospice payment rates are shown in the following table and are effective for care and services furnished on or after October 1, 2009, through September 30, 2010.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
<th>Wage Component Subject to Index</th>
<th>Non-Weighted Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$142.91</td>
<td>$ 98.19</td>
<td>$ 44.72</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full Rate = 24 hours of care</td>
<td>$834.10</td>
<td>$573.11</td>
<td>$260.99</td>
</tr>
<tr>
<td></td>
<td>$34.75= hourly rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$147.83</td>
<td>$ 80.02</td>
<td>$ 67.81</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$635.74</td>
<td>$406.94</td>
<td>$228.80</td>
</tr>
</tbody>
</table>


**Hospice Cap**


**Hospice Wage Index**

The Hospice Wage Index final rule will be effective October 1, 2009, and the final rule for the 2010 Hospice Wage Index is available at [http://edocket.access.gpo.gov/2009/pdf/E9-18553.pdf](http://edocket.access.gpo.gov/2009/pdf/E9-18553.pdf) on the Internet. The revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the wage index final rule.

**Important Reminder:**

Hospice providers are encouraged to split claims when the dates of service span separate fiscal years, e.g., claims with September and October services. This allows Medicare systems to price the September services at the FY 2009 rates and the October services at the FY 2010 rates. If you do not split such claims, all the services will be paid using the FY 2009 rates and your Medicare contractor will not perform subsequent adjustments for such claims paid totally at the 2009 rates.

**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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Medicare Contractor Provider Satisfaction Survey (MCPSS) Shows Cahaba Providers’ Satisfaction

The Centers for Medicare & Medicaid Services (CMS) conducts the Medicare Contractor Provider Satisfaction Survey (MCPSS) each year to assess provider satisfaction with their fee-for-service (FFS) contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to Medicare.

The 2009 MCPSS queried about 32,000 randomly selected providers, and the average satisfaction survey score across all FFS contractors was 4.54 on a scale of 1 (not at all satisfied) to 6 (completely satisfied). Contractors receive a report from CMS which details out their individual scores in comparison to the benchmark for other contractors.

This year, Cahaba’s overall MCPSS score was 5.01, well above the 4.54 average for all contractors. In addition, Cahaba ranked first among all regional home health intermediaries (RHHIs). For more information about the 2009 MCPSS, and the survey findings, go to the MCPSS Web page on the CMS Web site at [www.cms.hhs.gov/MCPSS](http://www.cms.hhs.gov/MCPSS) or the MCPSS Web pages at: [https://www.mcpsstudy.org/](https://www.mcpsstudy.org/)

We want to thank all of our providers who participated in this survey. These findings will be used by the various departments within Cahaba to continuously improve our service to our provider community.

Provider Contact Center Changes/Reminders Effective September 1, 2009

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6482 which included reminders and changes to guidelines for Medicare Provider Contact Centers (PCCs). The changes were effective September 1, 2009, and can be found in the Medicare Contract Beneficiary and Provider Communications Manual, (CMS Pub. 100-09), Chapter 6. Please share the following information with your staff.

Changes

- **Authentication of Beneficiary Elements** (§80.5.4 #11)—When customer service representatives (CSRs) from Cahaba’s home health and hospice PCC make a return call to a provider about a claim, the CSR can only provide the name and date of birth of the beneficiary. Before the CSR can release specific claim and/or personal health information, the provider is required to authenticate the beneficiary Health Insurance Claim Number (HICN) and dates of service.
Reminders

- **Pre-Approved Closures** (§30.2.7.1) Cahaba’s home health and hospice PCC is closed on the following holidays: New Year’s Day, Martin Luther King’s Day, President’s Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veteran’s Day, Thanksgiving Day, Day After Thanksgiving, and for 2009, the PCC will be closed on Christmas Eve and Christmas Day.

- **Provider Contact Centers Training Program** (§40.2.2 and 40.2.2.5)—CMS allows PCCs to close for up to 8 hours per month for CSR training and/or staff development. The goal is to help CSRs improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate retention of the facts of their training by increasing its frequency.

  **Note:** To review Cahaba’s home health and hospice PCC closures for CSR training, go to the select HH+H “Contact Us” Web Page, select “Phone Us” and then select “Closed for Training Dates”.

- **Contact Center Staffing** (§30.2.10)—To provide adequate coverage of incoming calls throughout the day, contact centers have the discretion to end a telephone inquiry if the CSR is placed on hold for two minutes or longer.

- **Recording Calls** (§30.2.13.3)—Calls are recorded as part of the quality assurance program for telephone inquiries. If you object to having your conversation recorded, the CSR will inform you that they record calls for the sole purpose of quality assurance and training and the recording system cannot be stopped by an individual CSR. If you still object and do not want to continue with the recorded call, the CSR may inform you to send your inquiry in writing.”

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

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**System and Provider Contact Center Availability for October and November Federal Holidays**

To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) encourages ongoing training of Customer Service Representatives and allows the provider contact centers to close on Federal Holidays to conduct training sessions. Therefore, on **Monday, October 12, 2009**, (Columbus Day), and **Wednesday, November 11, 2009**, (Veterans Day), the home health and hospice Provider Contact Center (1-877-299-4500 and 1-866-539-5592) will not be available. The Interactive Voice Response (IVR) unit will be available for providers to check beneficiary eligibility or the status of claims.

**System Availability**

The Fiscal Intermediary Standard System (FISS) will be available, **Monday, October 12, 2009**, and **Wednesday, November 11, 2009**, for providers to submit and correct claims as well as receive reports electronically. However, **FISS will not cycle during the evenings of October 12th and November 11, 2009**. This means that claims will not be sent to the Common Working File (CWF) during the nightly cycles, and Medicare Remittance Advices (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on October 12, 2009, and November 11, 2009.
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 October 30, 2009, for the quarter ending September 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:

If sending overnight:

Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA
400 E Court Ave
Des Moines, IA  50309-2019

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.

News from Cahaba for Home Health Providers

Update to Home Health Local Coverage Determination—Speech-Language Pathology

Our Medical Review department continues to develop Local Coverage Determinations (LCDs) and review existing LCDs to ensure policies remain accurate and up-to-date. As a result, please review the following LCD update. This update is based on the 2009-2010 Annual Update for ICD-9-CM coding.

Effective October 1, 2009, the LCD for Speech-Language Pathology–Home Health (L340) has been revised. The following ICD-9-CM codes have been added to the “ICD-9 Codes That Support Medical Necessity” list:

- 438.13;
- 438.14; and
- 784.42-784.44.
In addition, the code 784.5 is invalid and has been replaced with 784.51 and 784.59.

Providers are encouraged to review these revisions to ensure compliance. LCDs can be viewed on the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database Web page via Cahaba’s Active Local Coverage Determinations Web page.

News from Cahaba for Hospice Providers

New Hospice Billing Requirements: Change Request 6440

Change Request 6440 was issued by the Centers for Medicare & Medicaid Services (CMS) on May 15, 2009, and changes the way hospice providers submit their claims to Medicare. Below are a few specifics about these new billing requirements.

- Hospices may bill the new data optionally, beginning with dates of service October 1, 2009, and after.
- Hospices are required to bill the new data beginning with dates of service January 1, 2010.
- The new requirements apply to services provided under routine, continuous, and respite care. GIP care is not affected, and visits will continue to be billed as they are currently.
- Hospices must bill a separate revenue code line for each skilled nurse, aide and social worker visit provided.
- Hospices must now bill physical therapy, occupational therapy, and speech-language pathology visits. Each visit is billed on a separate revenue code line.
- Social worker phone calls to the patient or their family must also be billed when 1) the call is necessary for the palliation and management of the terminal illness and related conditions as described in the plan of care and 2) the call is related to providing and/or coordinating care to the patient and family, and documented in the clinical records.
- A corresponding HCPCS code (G0151-G0156) must be billed when a visit (nurse, aide, social worker, and therapist) is billed.
- Units for visits (nurse, aide, social worker, and therapist) must be billed in 15-minute increments. For example, 30 minutes = 2 units, 1 hour = 4 units, etc.

Please make sure that you are familiar with these changes, and have made any internal process changes necessary to ensure that your billing staff has this information available to them. In addition, if you use a billing software, check with your vendor to ensure they have made the necessary updates. If your billing software is unable to accommodate these new requirements, you may consider entering your claims directly into the Fiscal Intermediary Standard System (FISS).

Reminder – New Hospice Certification/Recertification Requirements

As a reminder, as of October 1, 2009, hospice certifications/recertifications are now required to include a brief narrative explaining the clinical findings that support a patient’s life expectancy of 6 months or less. This narrative can be part of the certification/recertification form or as an addendum to form.

- If the narrative is part of the form, it must be located immediately before the physician’s signature.
- If the narrative is an addendum, the physician must also sign addendum immediately following the narrative.

The form must also include a statement under the physician signature that attests to the fact that by signing the form, the physician confirms that the narrative is based on his/her review of the patient’s medical record or his/her examination of the patient.

In addition, the narrative must reflect the patient’s individual clinical circumstances, and cannot contain check boxes or standard language used for all patients. The narrative must be composed by the physician performing the certification/recertification, and cannot be completed by other hospice personnel.

Cahaba has updated its Sample Hospice Certification Form to reflect these new requirements. To view the final rule mandating this change, go to the August 6, 2009, Federal Register.
**October 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.

- **“Expanding Hospice Data Collection: CR 6440” and Staying on Top of Your Game: Hospice Billing Reminders and Common Billing Errors”**
  
  **Date:** October 26, 2009
  
  **Description:** These presentations are part of the Midwest Regional Conference on End of Life Care, which is being held at the Hyatt Regency Crown Center in Kansas City, MO. The event is sponsored by the Missouri Hospice & Palliative Care Association. For more information about this event, or to register, visit the Missouri Hospice & Palliative Care Association Web site at: [www.mohospice.org](http://www.mohospice.org)

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

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusting and Canceling Claims</td>
<td>Learn how to adjust or cancel claims.</td>
</tr>
<tr>
<td>Advanced Hospice Billing</td>
<td>Learn about advanced hospice billing topics.</td>
</tr>
<tr>
<td>Appeals Process</td>
<td>Learn about the Medicare appeals process.</td>
</tr>
<tr>
<td>Beginner Hospice Billing</td>
<td>Learn the basics of hospice billing.</td>
</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>
</tr>
<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>
</tr>
<tr>
<td>Comprehending Medicare Claims Processing</td>
<td>Learn about Medicare claims processing.</td>
</tr>
<tr>
<td>Medicare Coding (Insight into)</td>
<td>Learn the basics about Medicare coding.</td>
</tr>
<tr>
<td>Medicare Cost Report (Introduction to)</td>
<td>Learn the basics about the Medicare Cost Report</td>
</tr>
<tr>
<td>Medical Review (Getting a view of)</td>
<td>Learn the basics of the Medical review process.</td>
</tr>
<tr>
<td>Medicare Secondary Payer</td>
<td>Learn the basics of Medicare Secondary Payer.</td>
</tr>
</tbody>
</table>
“Online Courses” (Continued)

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of Medicare</td>
<td>Learn the basics about the Medicare program.</td>
</tr>
<tr>
<td>Provider Enrollment</td>
<td>Learn about provider enrollment and how to apply.</td>
</tr>
<tr>
<td>Verifying Beneficiary Eligibility</td>
<td>Learn how to identify various eligibility information by using ELGA and ELGH.</td>
</tr>
</tbody>
</table>

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.