Home Health & Hospice Medicare A Newsline

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

April 1, 2011 **Vol. 18, No. 7**

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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J15 Transition—Are You Ready!
Cahaba encourages all home health and hospice providers who currently submit claims to Cahaba to stay informed of the latest J15 transition news. Visit CIGNA's J15 Web site often at http://www.cignagovernmentservices.com/j15/index.html and enroll in their J15 Listserv to receive important J15 news.

Key for Icons: 🏠 Home Health Providers ♥ Hospice Providers

The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC as their Fiscal Intermediary or Regional Home Health Intermediary. The CPT codes, descriptors and other data only are copyright © 2011 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

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News Flash Messages from CMS for Home Health and Hospice Providers

Calendar Year 2011 is the Official 5010/D.0 Transition Year

Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and the National Council for Prescription Drug Program's (NCPDP) version D.0 standards as of January 1, 2012. To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses, and billing services to schedule testing with their local MAC as soon as possible. Medicare also encourages you to stay current on 5010/D.0 news and helpful tools by visiting http://www.cms.gov/Versions5010andD0/ on its Web site. ***Test early! Test often!***

2011 Versions of the ICD-10-CM and ICD-10-PCS Crosswalks

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the General Equivalence Mappings (GEMs) at http://www.cms.gov/ICD10 on the ICD-10 Web site. See the links on that page for 2011 ICD-10-CM and GEMs, and 2011 ICD-10-PCS and GEMs. In addition, CMS has also posted a document, "ICD-10 GEMs 2011 Version Update, Update Summary". This document describes the number of comments CMS received, the type of changes recommended, the types of changes made based on the comments, the types of comments not accepted, and the reasons why some comments were not accepted.

New Frequently Asked Questions (FAQs) about ICD-10 Implementation

The Centers for Medicare & Medicaid Services (CMS) has posted two new frequently asked questions (FAQs) about ICD-10 national provider teleconferences and the partial code freeze.

To access these FAQs, please visit the CMS ICD-10 web page at http://www.cms.gov/ICD10 , select the **Medicare Fee-for-Service Provider Resources** link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section, and select "ICD-10 FAQs".

Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

Important Information: Timely Filing (MM7337-revision to News Flash)

If you are a Medicare Fee-For-Service (FFS) physician, provider, or supplier submitting claims to Medicare for payment, this is very important information you need to know. Effective immediately, any Medicare Fee-For-Service claim with a date of service on or after January 1, 2010, must be received by your Medicare contractor no later than one Calendar Year (12 months) from the claim's date of service – or Medicare will reject the claim. For additional information, see Medicare Learning Network (MLN) Matters® Articles MM6960 at http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf and MM7080 at http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site. You can also listen to a podcast on this subject by visiting http://www.cms.gov/MLNProducts/MLM/list.asp on the same site.

Note from Cahaba: Additional information about timely filing can be found on the Timely Claim Filing Requirements Web page and the 02/16/2011 article, Appropriately Using The Cahaba GBA Medicare Home Health And Hospice Redetermination Request Form found on the HH+H News Web page.

2011 Medicare Contractor Provider Satisfaction Survey (MCPSS)

The Centers for Medicare & Medicaid Services (CMS) has launched the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) and is waiting to hear from you. This survey offers Medicare Fee-For-Service (FFS) providers and suppliers an opportunity to provide feedback on interactions with their Medicare contractors. The survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate were notified starting in January. If selected to participate, please complete this important survey. To learn more about the MCPSS, please visit http://www.cms.gov/MCPSS on the CMS Web site.

It's Not too Late to Give and Get the Flu Vaccine

Take advantage of each office visit and continue to protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) recommends that patients, health care workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.**

February 2011 "Quarterly Provider Compliance Newsletter" Released

The Medicare Learning Network® (MLN) has released the February 2011 issue of the "Medicare Quarterly Provider Compliance Newsletter," which is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. In this issue, a number of Recovery Audit findings that affect inpatient hospitals, physicians, and durable medical equipment (DME) suppliers are presented. This publication is issued on a quarterly basis and highlights the top issues of that particular quarter, as identified through a variety of sources. The current issue may be downloaded at http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN905712.pdf on the Internet. An archive and searchable index of previously-issued newsletters are also now available at: http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf

The DMEPOS Competitive Bidding Program Fact Sheet

The new Medicare Learning Network® (MLN) fact sheet "The DMEPOS Competitive Bidding Program: Fact Sheet for Referral Agents" is now available in both downloadable and hardcopy formats. The downloadable version is available at http://www.cms.gov/MLNProducts/downloads/DME_Ref_Agt_Factsheet_ICN900927.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site. To order a hardcopy, free of charge, please visit the MLN homepage at http://www.cms.gov/mlngeninfo on the CMS Web site. Click on "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

Subscribe to a Medicare FFS Provider Listserv

Looking for the latest Medicare Fee-For-Service (FFS) information? Then subscribe to a Medicare FFS Provider listserv that suits your needs! For information on how to register and start receiving the latest news, go to http://www.cms.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf on the Centers for Medicare & Medicaid Services (CMS) Web site.

Medicare Learning Network (MLN) Opinion Page

The Medicare Learning Network® (MLN) is interested in what you have to say. Regardless of whether you have an MLN account or not, you can evaluate the MLN products, services, and activities that you have participated in, received, or downloaded.

If you don't have an MLN account or don't want to log in, don't worry: the MLN offers a new anonymous evaluation function that allows you to complete an evaluation without logging in. Visit the MLN Opinion Page (http://www.cms.gov/MLNProducts/85_Opinion.asp) and click on 'MLN Opinion Page' in the 'Related Links Inside CMS' section at the bottom of the page. Click on the underlined title of the product, service, or activity you want to evaluate and click on the 'Take the anonymous evaluation for this product' link that will appear on the right-hand side. A new window will open containing the product evaluation.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services, and activities and to develop products, services, and activities that better meet your educational needs. If you have any suggestions related to MLN product topics or formats, please send them to MLN@cms.hhs.gov.

"Medicaid Coverage of Medicare Beneficiaries (Dual Eligible's) At a Glance" Fact Sheet Revised

The revised publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligible's) At a Glance" (revised December 2011) is now available from the Medicare Learning Network at:
http://www.cms.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

Home Health Prospective Payment System Fact Sheet Revised

The "Home Health Prospective Payment System" fact sheet (revised January 2011) is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/HomeHlthProsPaymt.pdf from the Medicare Learning Network®. This fact sheet is designed to provide education on the Home Health Prospective Payment System (HH PPS) including background information and consolidated billing requirements, coverage of HH services, elements of the HH PPS, and additional requirements.

Updated Educational Resources on the Home Health Agency Web Page

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of updated educational resources on Section 6407 of the Affordable Care Act (ACA) of 2010 to the Home Health Agency Web page at http://www.cms.gov/center/hha.asp on CMS Web site.

Section 6407 of the Affordable Care Act (ACA) of 2010 established a physician face-to-face encounter requirement for certification of eligibility for home health services. Before a physician can certify a patient's eligibility for Medicare home health services, the law mandates that the physician must document that he or she, or a non-physician practitioner working with the certifying physician, has had a face-to-face encounter with the patient. This provision is a requirement for home health payment.

The educational resources added to the Web page include a PowerPoint slide presentation, a Special Edition MLN Matters article and questions and answers related to this provision.

News from CMS for Home Health and Hospice Providers

Important Reminders about HIPAA 5010 & D.0 Implementation

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.gov/MLNMattersArticles/**

MLN Matters® Number: SE1106
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
This Special Edition MLN Matters® article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
STOP – Impact to You
The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that Electronic Data Interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

CAUTION – What You Need to Know
Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This Special Edition MLN Matters® article is being provided by CMS to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 Version 5010 and NCPDP Version D.0 standards. Remember that the HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.

GO – What You Need to Do
In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

More information about Medicare's EDI requirements can be found in the "*Medicare Claims Processing Manual*," Chapter 24 – "General EDI and EDI Support Requirements, Electronic Claims and Coordination

of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at http://www.cms.gov/manuals/downloads/clm104c24.pdf on the CMS Web site. Electronic billing and EDI transaction information can be found at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS Web site. This section contains information on:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the "*Medicare Claims Processing Manual*" that contain further information on these types of transactions;
- The Administrative Simplification Compliance Act (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," can be found at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the US Government Printing Office (GSP) Web site.

Subsequently, CMS is performing activities to convert from processing the ASC X12 Version 4010A1 to HIPAA ASC X12 Version 5010, and the NCPDP Version 5.1 to NCPDP Version D.0.

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- **Level I compliance** means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."
- **Level II compliance** means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare Fee-for-Service implementation schedule is:

- **Level I** April 1, 2010, through December 31, 2010;
- **Level II** January 1, 2011, through December 31, 2011; and
- **Fully compliant** on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010, and NCPDP EDI standards Version 5.1 with Version D.0. For more information see http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp on the CMS Web site.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare Fee-for-Service. Maintenance will be performed without notification, as needed to support Medicare Fee-for-Service.

Readiness Assessment 1– Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 Errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit http://www.cms.gov/Versions5010andD0/downloads/readiness_1.pdf to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing Version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful Web links go to http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp on the CMS Web site.

Readiness Assessment 2 – What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of Versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education – Transition Year Activities can be found at http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf on the CMS Web site.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at http://www.cms.gov/Versions5010andD0/ on the CMS Web site;
- Educational Resources (i.e., Medicare Learning Network® (MLN) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp on the CMS Web site; and
- The dedicated HIPAA 5010/D.0 Project Web page, which includes technical documents and communications at national conferences, can be found at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp on the CMS Web site.

Errata Requirements and Testing Schedule
HIPAA Version 5010 has new Errata, which can be found at http://www.cms.gov/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf on the CMS Web site. According to the published regulation (Federal Register, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. **Compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.**

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS Web site.

CMS 5010 Provider Outreach and Education Materials
CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS Web site:

- Version 5010 – the new version of the X12 standards for HIPAA transactions;
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at http://www.cms.gov/Versions5010andD0/01_overview.asp on the CMS Web site may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The "Overview" Web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- **Federal Regulation & Notices** (http://www.cms.gov/Versions5010andD0/20_Federal_Regulation_and_Notices.asp)
  This Web page contains general information related to Federal regulations and notices and contains the following link to the Final Rule for X12 5010, D.0 and 3.0 document. See http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the GPO website.
- **CMS Communications** (http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp)
  This CMS Communications Web page includes Versions 5010 & D.0 implementation information and the following downloads:
  - 5010 Implementation Calendar [PDF, 325KB]; see http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf on the CMS Web site.
  - Readiness Assessment - What do you need to have in place to test with your MAC? [PDF, 241KB]; see http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf on the CMS Web site.

- **Educational Resources** (http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp)

  The Educational Resources Web page includes information designed to increase national awareness and assist in the implementation of Versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:

  - **Version 5010 Resource Card [PDF, 243KB]** (see http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf);
  - **Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 Fact Sheet [PDF, 1208KB]** (see http://www.cms.gov/Versions5010andD0/Downloads/w5010TransitionFctSht.pdf);
  - **Checklist for Level I Testing Activities [PDF, 324 KB]** (see http://www.cms.gov/Versions5010andD0/Downloads/w5010PrepChklst.pdf);
  - **Provider Action Checklist for a Smooth Transition [PDF, 333KB]** (see http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf); and
  - **Versions 5010 and D.0 MLN Matters® Articles [PDF, 31KB]** (see http://www.cms.gov/Versions5010andD0/Downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf on the CMS Web site).

- **5010 National Calls** (http://www.cms.gov/Versions5010andD0/V50/)

  Throughout the implementation of Version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 Web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional Information

A Special Edition MLN Matters® article on the ICD-10 code set can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf** on the CMS Web site.

CMS is also using the Open Door Forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the Open Door Forums can be found at http://www.cms.hhs.gov/OpenDoorForums/ on the CMS Web site. Information about listservs (email updates) can be found at http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/ on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

Note from Cahaba: For information about testing the HIPAA Version 5010, please access the 5010 Companion Document at: https://www.cahabagba.com/part_a/edi/5010CompanionDocument.pdf on Cahaba's Web site. For further questions about testing, please contact the Electronic Data Interchange (EDI) Services department at (866) 839-2441.

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. CPT only copyright 2011 American Medical Association.

Correction to Chapter 5, Section 20.2 of the Internet-Only Claims Processing Manual

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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7315
Related CR Release Date: February 18, 2011
Related CR Transmittal #: R2160CP
Related Change Request (CR) #:7315
Effective Date: May 19, 2011
Implementation Date: May 19, 2011

Provider Types Affected

Providers submitting claims to Medicare contractors (A/B Medicare administrative contractors (A/B MACs) fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs)) for outpatient rehabilitation and comprehensive outpatient rehabilitation facility/outpatient therapy (CORF/OPT) services provided to Medicare beneficiaries are affected.

Provider Action Needed

STOP – Impact to You

This article is informational and is based on CR 7315 that corrects a cross reference mentioned twice in Pub. 100-04, Chapter 5, Section 20.2 of the Internet-Only Manual (IOM) *Medicare Claims Processing Manual*.

CAUTION – What You Need to Know

The first reference states: "Pub. 100-02, Chapter 15, Section 230.3B, Treatment Notes, indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note." **The second reference states:** "For documentation in the medical record of the services provided see Pub. 100-02, Chapter 15, Section 230.3, Documentation, Treatment Notes."

Both cross references are incorrect as stated and should refer to Pub. 100-02, Chapter 15, Section 220.3, Treatment Notes of the *Medicare Benefit Policy Manual* versus Chapter 15, Section 230.3.

GO – What You Need to Do

See the official instruction attached to CR 7315. The attachment includes the corrected version of the *Medicare Claims Processing Manual* Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services; Section 20.2 Reporting of Service Units with Healthcare Common Procedure Coding System (HCPCS).

Additional Information

The official instruction, CR 7315, issued to your Medicare A/B MAC, FI and RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2160CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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April 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.1

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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7344
Related CR Release Date: March 11, 2011
Related CR Transmittal #: R2172CP
Related Change Request (CR) #: 7344
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the Home Health Prospective Payment System or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider Action Needed

This article is based on CR 7344, which describes changes to the I/OCE and OPPS to be implemented in the April 2011 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7344 describes changes to billing instructions for various payment policies implemented in the April 2011 OPPS update. The April 2011 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR 7344.

Note: The full list of I/OCE specifications can now be found at http://www.cms.gov/OutpatientCodeEdit/ on the CMS Web site.

A summary of the changes for April 2011 is within Appendix M of Attachment A of CR 7344 and that summary is captured in the following key points, effective April 1, 2011:

- Make Healthcare Common Procedures Coding System (HCPCS)/Ambulatory Payment Classification (APC)/Status Indicator (SI) changes (a summary of these data changes are attached to CR 7344);
- Remove CPT code 88177 from the female-only procedures list. Edit 8 is affected;
- Add new modifier '33' to the valid modifier list. Edit 22 is affected;

- Implement version 17.0 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers). Edits 19, 20, 39, and 40 are affected; and
- Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS Web site.

Additional Information

The official instruction, CR 7344 issued to your Medicare MAC, RHHI or FI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2172CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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Healthcare Provider Taxonomy Codes (HPTC) Update April 2011

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim. **For home health and hospice claims, the taxonomy code is not required for Medicare claims processing**. However, if a taxonomy code is reported on claims submitted in the X12 837-I format, the taxonomy code must be valid according to the HPTC code set.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year. Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The HPTC code list is available from the Washington Publishing Company at http://www.wpc-edi.com/codes/taxonomy, or at www.nucc.org/taxonomy on the NUCC Web site. The PDF download of the codes is also available from the NUCC site at:
www.nucc.org/index.php?option=com_content&task=view&id=91&Itemid=53

The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, revisions made since the last release can be identified by the color code; new items are green, modified items are orange, and inactive items are red. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.

April Update to the Calendar Year (CY) 2011 Medicare Physician Fee Schedule Database (MPFSDB)—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network (MLN) Matters* article, "April Update to the Calendar Year (CY) 2011 Medicare Physician Fee Schedule Database (MPFSDB)," which was published in the March 1, 2011, *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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7319
Related CR Release Date: March 18, 2011
Related CR Transmittal #: R2180CP
Related Change Request (CR) #: 7319
Effective Date: January 1, 2011
Implementation Date: April 4, 2011

Note: This article was revised, on March 20, 2011, to reflect the revised CR 7319 issued on March 18, 2011, to change the MPFS payment file names described in the Recurring Update Notification in the section titled: Revised MPFS Payment File Names. Also, the CR release date, transmittal number, and the Web address for accessing CR 7319 were changed. All other information remains the same. A previous update added the section with the heading of "Correction to Payment File OPPS Cap "Imaging Payment Amount" Field for CPT Code 92227".

Provider Types Affected

This article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (fiscal intermediaries, carriers or Part A/B Medicare administrative contractors (A/B MACs), and regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

What You Need to Know

Payment files were issued to contractors based upon the CY 2011 MPFS Final Rule, released on November 2, 2010, and published in the *Federal Register* on November 29, 2010. As previously described in CR 7300, these payment files were modified in accordance with the MPFS Final Rule Correction Notice released on December 30, 2010, and published in the *Federal Register* on January 11, 2011, and by relevant statutory changes applicable January 1, 2011, including the Physician Payment and Therapy Relief Act of 2010, and the Medicare and Medicaid Extenders Act of 2010.

This article is based on CR 7319, which details changes included in the April quarterly update to those payment files. **Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that were processed prior to implementation of CR 7319. However, contractors will adjust claims brought to their attention.** Please be sure to inform your staff of these changes.

Background

Medicare Physician Fee Schedule Database (MPFSDB) Payment File Revisions

In order to reflect appropriate payment policy in line with the CY 2011 MPFS Final Rule, some payment indicators and Practice Expense (PE) Relative-Value Units (RVUs) have been revised. New MPFS payment files have been created that include these changes.

MPFSDB Indicator Changes
The following HCPCS codes have MPFSDB indicator changes:

HCPCS Code	Short Descriptor	Indicator
31579	Diagnostic laryngoscopy	Global Surgery: 000
57155	Insert uteri tandems/ovoids	Co-Surgeons: 2
64613	Destroy nerve neck muscle	Bilateral Surgery: 2
64614	Destroy nerve extrem musc	Bilateral Surgery: 2
77071	X-ray stress view	Bilateral Surgery: 2 ‘
92511	Nasopharyngoscopy	Global Surgery: 000
93464 26	Exercise w/hemodynamic meas	Multiple Surgery: 0

Practice Expense RVU Changes
The following HCPCS codes have Practice Expense RVU changes. A detailed description of these changes can be found in CR 7319.

HCPCS Code	Short Descriptor
93503	Insert/place heart catheter
93224	Ecg monit/reprt up to 48 hrs
93225	Ecg monit/reprt up to 48 hrs
93226	Ecg monit/reprt up to 48 hrs

Added HCPCS Code
The following HCPCS code has been added, effective April 1, 2011. More information on this addition can be found in CRs 7319 and 7299.

HCPCS Code	Short Descriptor
Q2040	Incobotulinumtoxin A

Discontinued HCPCS Codes
The following HCPCS codes are discontinued for dates of service on or after January 1, 2011, that are processed on or after April 4, 2011.

HCPCS Code	Short Descriptor
90470	Immune admin H1N1 im/nasal
90663	Flu vacc pandemic H1N1

The following HCPCS codes are discontinued for dates of service on or after April 1, 2011, that are processed on or after April 4, 2011.

HCPCS Code	Short Descriptor
Q1003	Ntiol category 3
S2270	Insertion vaginal cylinder
S2344	Endosc balloon sinuplasty
S3905	Auto handheld diag nerv test

Correction to Payment File OPPS Cap "Imaging Payment Amount" Field for CPT Code 92227
CPT Code 92227 (Remote Dx retinal imaging), is subject to the OPPS payment cap determination and has an Imaging Cap indicator of 1. The CY 2011 MPFS Relative Value File correctly lists OPPS payment amounts (PE=0.53 and MP =0.02) for this code; however, these values were not carried over to the Imaging Payment Amount field in the Medicare contactor payment files, which listed the values as 0.00 for all carriers. This will be corrected in the MPFS payment files released for the April Quarterly Update, effective January 1, 2011.

Additional Information
The official instruction, CR 7319, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2180CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – April 2011 Update—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) *Matters* article, "Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – April 2011 Update," which was published in the March 1, 2011, *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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7299
Related CR Release Date: February 4, 2011
Related CR Transmittal #: R2147CP
Related Change Request (CR) #: 7299
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Note: This article was revised on February 22, 2011, to show the correct status indicator of "X" for HCPCS code Q2040. All other information is the same.

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

What You Need to Know
CR 7299 announces that effective for claims with dates of service on or after April 1, 2011, HCPCS code Q2040 (Injection, Incobotulinumtoxin A, 1 Unit) will be payable by Medicare. Specifically, your contractors will accept Q2040 as a valid HCPCS code for dates of service on or after April 1, 2011, using Type of Service (TOS) 1, 9, and Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator "X" (Statutorily Excluded from Physician Fee Schedule). You should make sure that your billing staffs are aware of this HCPCS code change.

Additional Information
You can find the official instruction, CR 7299, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2147CP.pdf on the CMS Web site. If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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Reporting of Recoupment for Overpayment on the Remittance Advice (RA)—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) *Matters* article, "Reporting of Recoupment for Overpayment on the Remittance Advice (RA)," which was published in the May 1, 2010, *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.gov/MLNMattersArticles/

MLN Matters® Number: MM6870 Revised
Related CR Release Date: March 4, 2011
Related CR Transmittal #: R866OTN

Related Change Request (CR) #: 6870
Effective Date: July 1, 2010
Implementation Date: July 6, 2010, except October 3, 2011, for claims processed by the FISS system used by FIs and A/B MACs

Note: This article was revised on March 4, 2011, to reflect changes made to CR6870. The CR was changed to amend the implementation date to October 3, 2011, for claims processed by Medicare contractors using the Fiscal Intermediary Shared System (FISS). The article was changed accordingly. All other information is the same.

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries. (CR 6870 does not apply to suppliers billing durable medical equipment (DME) MACs.)

Provider Action Needed

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

Background

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

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

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the Medicare Learning Network® (MLN) Matters® article related to CR 6183 at http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf on the CMS Web site.)

Under the scenario just described, the RAC has to report the actual recoupment in two steps:

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

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

CR 6870 instructs the Medicare System Maintainers (Fiscal Intermediary Standard System (FISS_ and Multi Carrier System (MCS)) how to report on the RA when:

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

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

Step I:

Claim Level:

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

Provider Level:

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

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

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

Step II:

Claim Level:

No additional information at this step

Provider Level:

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

PLB 03-2 shows the detail:

MLN Matters® Number: MM6870 Related Change Request Number: 6870

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Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the actual amount being recouped.

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

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

The official instruction, CR 6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R866OTN.pdf on the CMS Web site.

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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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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News from CMS for Home Health Providers

Payment Update and Common Working File (CWF) Editing for Influenza Virus Vaccine and Pneumococcal Vaccine (PPV) Codes

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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7128
Related CR Release Date: February 11, 2011
Related CR Transmittal #: R2154CP
Related Change Request (CR) #: 7128
Effective Date: October 1, 2010
Implementation Date: July 5, 2011

Provider Types Affected

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

What You Need to Know

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

Background

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

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

Basis for Influenza Vaccine and PPV Payments

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to hospitals (Types of Bill (TOB) 12X and 13X), skilled nursing facilities (SNFs) (TOBs 22X and 23X), home health agencies (HHAs) (TOB 34X), hospital-based renal dialysis facilities (RDFs) (TOB 72X), and critical access hospitals (CAHs) (TOB 85X) is based on reasonable cost;

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to Indian Health Service (IHS) hospitals (TOB 12X, 13X) and IHS CAHs (TOB 85X) is based on 95% of the Average Wholesale Price (AWP); and
- The payment for influenza virus vaccine HCPCS code 90662 and PPV code 90670 to comprehensive outpatient rehabilitation facilities (TOB 75X) and independent RDFs (TOB 72X) is based on the lower of the actual charge or 95% of the AWP.

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

Additional Information

The official instruction, CR 7128 issued to your carrier, FI or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2154CP.pdf on the CMS Web site. If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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January 2011 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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7271
Related CR Release Date: January 24, 2011
Related CR Transmittal #: R2141CP

Related Change Request (CR) #: 7271
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

Providers submitting claims to Medicare Contractors (fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs) and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

This article is based on CR 7271 which provides the January 2011 update for the OPPS, describes changes to and billing instructions for various payment policies implemented in the 2011 OPPS updates, and includes instructions addressing hold harmless payment. The January 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and revenue code additions, changes, and deletions identified in CR7271. Be sure your billing staff is aware of these changes.

Background

The Medicare and Medicaid Extenders Act of 2010 (MMEA) extends the Outpatient Hold Harmless Provision for small rural hospitals with 100 or fewer beds and all Sole Community and Essential Access Hospitals and reclassification wage indices originally authorized under Section 508 of MMA. CR 7271 also includes instructions addressing hold harmless payment. CMS will issue a separate notification to address the extension of Section 508 reclassification wage indices.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252, Transmittal 2114, "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0." The related article is at http://www.cms.gov/MLNMattersArticles/downloads/MM7252.pdf on the CMS Web site.

Key changes to and billing instructions for various payment policies implemented in the January 2011 OPPS update are detailed below.

Key OPPS Updates for January 2011

Changes to Device Edits for January 2011

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Since January 1, 2007, CMS also has required 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 device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS rate-setting.

The most current edits for both types of device edits can be found at http://www.cms.gov/HospitalOutpatientPPS/ on the CMS Web site. Failure to pass these edits will result in the claim being returned to the provider.

Payment for Multiple Imaging Composite Ambulatory Payment Classifications (APCs)

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic determines the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

The composite APC payment methodology for multiple imaging services utilizes three imaging families (Ultrasound, CT and CTA, and MRI and MRA) and five composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes. Specifically, CMS added CPT code 74176 (Computed tomography, abdomen and pelvis; without contrast material), CPT code 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)), and CPT code 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions) to the CT and CTA family. These codes are new for CY 2011. CMS also added HCPCS codes C8931 (Magnetic resonance angiography with contrast, spinal canal and contents), C8932 (Magnetic resonance angiography without contrast, spinal canal and contents), C8933 (Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents), C8934 (Magnetic resonance angiography with contrast, upper extremity), C8935 (Magnetic resonance angiography without contrast, upper extremity), and C8936 (Magnetic resonance angiography without contrast followed by with contrast, upper extremity), to the MRI and MRA family. These codes were recognized for OPPS payment in the October 2010 OPPS Update (Transmittal 2061, CR 7117, dated September 17, 2010). See http://www.cms.gov/Transmittals/downloads/R2061CP.pdf on the CMS Web site.

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2011 are provided in Table 1 of CR 7271.

Partial Hospitalization APCs

For CY 2011, CMS is creating four separate PHP per diem payment rates: two for Community Mental Health Centers (CMHCs) (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). CMS will be implementing a two-year transition for the two CMHC PHP per diem rates to mitigate their payment reduction. The APCs for the CMHCs are: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). The APCs for the hospital-based PHPs are: APC 0175 (Level I Partial Hospitalization (3 services)) and APC 0176 (Level Level II Partial Hospitalization (4 or more services)).

When a CMHC provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176.

The tables below provide the updated per diem payment rates:

CY 2011 Median Per Diem Costs for CMHC PHP Services Plus Transition

APC	Group Title	Median Per Diem Costs Plus Transition
0172	Level I Partial Hospitalization (3 services) for CMHCs	$128.25
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$162.67

CY 2011 Median Per Diem Costs for Hospital-Based PHP Services

APC	Group Title	Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$202.71
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$235.79

Changes to Regulations to Incorporate Provisions of the Health Care and Education Reconciliation Act (HCERA) 2010

Section 1301 (a) and (b) of HCERA 2010 established new requirements for CMHCs and amended the definition of a PHP. Section 1301 (a) of HCERA revised the definition of a CMHC by adding a requirement that the CMHC must provide at least 40 percent of its services to non-Medicare beneficiaries, effective April 1, 2010. Section 1301 (b) of HCERA amends the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting".

Mental Health Services Composite APC 0034

Since CY 2009, CMS has set the annual payment rate for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment. For CY 2011, CMS is adapting a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a CMHC from payment made for services furnished in a hospital. CMS has modified the titles of APCs 0172 (Level I Partial Hospitalization (3 services) for CMHCs) and 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs) to solely reflect CMHC-based partial hospitalization services. Additionally, CMS has created APCs 0175 (Level I Partial Hospitalization (3 services) for Hospital-Based Partial Hospitalization Programs (PHPs)) and 0176 (Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs) to pay for Hospital-Based partial hospitalization services. In accordance with CMS policy to pay for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment, for CY 2011, CMS will use the hospital-based partial hospitalization APC 0176 as the daily payment cap for less intensive mental health services provided in hospital outpatient departments and will set the CY 2011 payment rate for APC 0034 at the same rate as APC 0176. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 10.2.1 to reflect this change. This Manual update is included as an attachment to CR 7271.

The I/OCE will continue to determine whether to pay specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. Through the I/OCE, when the payment for the specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment, those specified mental health services would be assigned to APC 0034 (Mental Health Services Composite), which has the same payment rate as APC 0176, and the hospital would be paid one unit of APC 0034.

Reporting Hospital Critical Care Services Under the OPPS

For CY 2010 and in prior years, the American Medical Association (AMA) Common Procedural Terminology (CPT) Editorial Panel has defined critical care CPT codes 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 99292 (critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service)) to include a wide range of ancillary services such as

electrocardiograms, chest X-rays and pulse oximetry. As CMS has stated in its manual instructions, hospitals should report in accordance with CPT guidance unless CMS instructs otherwise. For critical care in particular, CMS instructs hospitals that any services that the CPT Editorial Panel indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by the CPT Editorial Panel) should not be billed separately. Instead, hospitals should report charges for any services provided as part of the critical care services.

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

CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 160.1, to reflect the revised critical care reporting guidelines and OPPS payment policy and that revised manual chapter is included as an attachment to CR 7271.

Waiver of Cost-Sharing for Preventive Services

The Affordable Care Act waives any copayment and deductible that would otherwise apply for the defined set of preventive services to which the U.S. Preventive Services Task Force (USPSTF; see http://www.ahrq.gov/clinic/cps3dix.htm on the Internet) has given a grade of A or B, as well as, the Initial Preventive Physical Examination (IPPE), and the Annual Wellness Visit (AWV) providing Personalized Preventive Plan Services (PPPS). These provisions are effective for services furnished on and after January 1, 2011. CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Section 30, which references the 25% copayment for screening colonoscopies and screening flexible sigmoidoscopies, effective prior to January 1, 2011, to reflect this change. This Manual revision is included as an attachment to CR 7271. Further information on the implementation of waiver of cost-sharing for preventive services as prescribed by the Affordable Care Act can be found in CR 7012, Transmittal 739, issued on July 30, 2010.

Billing for Tobacco Cessation Counseling

Effective for claims with dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries, 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. To implement this recent coverage determination, CMS created new C-codes and G-codes to report tobacco cessation counseling service. The long descriptors for both the C-codes and G-codes appear in the following table:

Tobacco Cessation Counseling Services

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	CY 2011 Status Indicator	CY 2011 APC
G0436	C9801	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	X	0031
G0437	C9802	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	X	0031

For dates of service between August 25, 2010, through December 31, 2010, hospital outpatient facilities must have reported either HCPCS code C9801 or C9802 for tobacco cessation counseling services. HCPCS codes C9801 and C9802 will be deleted December 31, 2010, and replaced with HCPCS codes G0436 and G0437, respectively, effective January 1, 2011. Both HCPCS codes G0436 and G0437 have been assigned to the same status indicators and APC assignments as their predecessor C-codes. Further reporting guidelines on tobacco cessation counseling services can be found in the *Medicare Claims Processing Manual*, Chapter 18, Section 150 and in CR 7133 (see the related MLN Matters® article at http://www.cms.gov/MLNMattersArticles/Downloads/MM7133.pdf on the CMS Web site).

Inpatient Only Services

With CR 7271, CMS is adding Section 180.7 Inpatient Only Services to the *Medicare Claims Processing Manual*, Chapter 4, to clarify that OPPS does not pay hospitals for an inpatient only procedure and related ancillary services provided on the same day. The Section 180.7 added to Chapter 4 of the *Medicare Claims Processing Manual* is included as an attachment to CR 7271.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Reporting HCPCS Codes for All 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.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is

the CMS standard rate-setting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPPS payments are based.

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

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

b. New Calendar Year 2011 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2011, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in the following table:

New CY 2011 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2011 SI	CY 2011 APC
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	G	9274
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	G	9275
C9276	Injection, cabazitaxel, 1 mg	G	9276
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	G	9277
C9278	Injection, incobotulinumtoxin A, 1 unit	G	9278
C9279	Injection, ibuprofen, 100 mg	G	9279
J0638	Injection, canakinumab, 1 mg	K	1311
J1559	Injection, immune globulin (Hizentra), 100 mg	K	1312
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg	N	N/A
J2358	Injection, olanzapine, long-acting, 1 mg	K	1331
J7196	Injection, antithrombin recombinant, 50 IU	K	1332
J7309	Methyl aminolevulinate (mal) for topical administration, 16.8%, 10 mg	K	1338
Q4118	Matristem micromatrix, 1 mg	K	1342
Q4121	Theraskin, per square centimeter	K	1345

c. Other Changes to CY 2011 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2011. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2010, and replaced with permanent HCPCS codes in CY 2011. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2011 HCPCS and CPT codes. The changes are detailed in Table 6 of CR 7271.

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

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was postponed beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2011, 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 2011 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2011, payment rates for many drugs and biologicals have changed from the values published in the CY 2011 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2010. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2011 release of the OPPS Pricer. CMS is not publishing the updated payment rates in CR 7271. However, the updated payment rates effective January 1, 2011, can be found in the January 2011 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp on the CMS Web site.

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

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed in the following table below and have been installed in the January 2011 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Your Medicare contractor will adjust any claims that you bring to their attention which were processed for these service dates prior to implementation of the corrected Pricer.

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

CY 2010 HCPCS Code	CY 2010 SI	CY 2010 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9543	K	1643	Y90 ibritumomab, rx	$30,581.01	$6,116.20
J0150	K	0379	Injection adenosine 6 MG	$13.74	$2.75

CY 2010 HCPCS Code	CY 2010 SI	CY 2010 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0641	G	1236	Levoleucovorin injection	$0.73	$0.14
J2430	K	0730	Pamidronate disodium /30 MG	$15.61	$3.12
J2850	K	1700	Inj secretin synthetic human	$26.97	$5.39
J9065	K	0858	Inj cladribine per 1 MG	$24.12	$4.82
J9178	K	1167	Inj, epirubicin hcl, 2 mg	$2.06	$0.41
J9185	K	0842	Fludarabine phosphate inj	$112.61	$22.52
J9200	K	0827	Floxuridine injection	$42.31	$8.46
J9206	K	0830	Irinotecan injection	$4.23	$0.85
J9208	K	0831	Ifosfomide injection	$30.95	$6.19
J9209	K	0732	Mesna injection	$4.96	$0.99
J9211	K	0832	Idarubicin hcl injection	$40.09	$8.02
J9263	K	1738	Oxaliplatin	$4.37	$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$44.07	$8.81

f. New Vaccine CPT Codes

One new vaccine code is effective for services provided beginning January 1, 2011. That code is 90654 (influenza virus vaccine, split virus, preservative free, for intradermal use) with a CY 2011 SI of E.

g. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

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

h. Correct Reporting of Units for Drugs

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

As discussed in the *Medicare Claims Processing Manual*, Chapter 17, Section 40, CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

i. Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data is unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, for January 1, 2011, the status indicator for separately payable therapeutic radiopharmaceuticals is "K" to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Nonpass-Through Separately Payable Therapeutic Radiopharmaceuticals for January 1, 2011

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 APC	Final CY 2011 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

j. **Reporting of Outpatient Diagnostic Nuclear Medicine Procedures**
With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

When a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under the Social Security Act (Section 1861(w)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet), and as discussed in 42 CFR 410.28(a)(1) (See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr410.28.pdf on the Internet) and defined in 42 CFR 409.3 (See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr409.3.pdf on the Internet), where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and CMS would expect both services to be performed together.

k. **Implementation of the FB modifier for Diagnostic Radiopharmaceuticals**
As discussed in the CY 2011 OPPS/ASC final rule with comment period, beginning on January 1, 2011, CMS is extending the use of the "FB" modifier ("Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples") to diagnostic radiopharmaceuticals received free of charge or with full credit. Hospitals should report diagnostic radiopharmaceuticals received free of charge (including free samples or trial diagnostic radiopharmaceuticals received free of charge) by reporting the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table 10 below. In addition, hospitals should report a token charge of less than $1.01 for diagnostic radiopharmaceuticals received free of charge or with full credit. The payment amount for the procedures in the APCs listed in Table 10 below will be reduced by the full "policy-packaged" offset amount appropriate for diagnostic radiopharmaceuticals.

l. **Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals**
Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR 6416 (Transmittal 1702; see https://www.cms.gov/transmittals/downloads/R1702CP.pdf on the CMS Web site), pass-through

payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code A9582 (Iobenguane, I-123, diagnostic, per study dose, up to 15 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G". HCPCS code A9582 will continue on pass-through status for CY 2011 and therefore, when HCPCS code A9582 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code A9582 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

The "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures may be found on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2011 OPPS Offset Amounts by APC.

CY 2011 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table:

APCs to Which Nuclear Medicine Procedures are Assigned for CY 2011

CY 2011 APC	CY 2011 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging

CY 2011 APC	CY 2011 APC Title
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

m. Payment Offset for Pass-Through Contrast Agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR 6751 (Transmittal 1882; see http://www.cms.gov/transmittals/downloads/R1882CP.pdf on the CMS Web site), CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2011 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 11 of CR 7271. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used. For CY 2011, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in Table 11 of CR 7271 on the same date of service, a specific pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

For CY 2011, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. In addition, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) describes a contrast agent that has been granted pass-through status beginning January 1, 2011, and will be subject to the payment offset methodology for contrast agents. Both HCPCS codes A9583 and C9275 will be assigned status indicator "G". Therefore, in CY 2011, CMS will reduce the payment for HCPCS code A9583 and C9275 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9583 or C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in Table 11 below. The "policy-packaged" portions of the CY 2011 APC payments that are the offset amounts may be found on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2011 OPPS Offset Amounts by APC.

When HCPCS code A9583 or C9275 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in Table 11 of CR 7271, the OPPS Pricer will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported on the claim with a single occurrence of either HCPCS code A9583 or C0275, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-

through contrast agent, the OPPS Pricer will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9583 or C9275, the OPPS Pricer will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9583 or C9275. The offset will cease to apply when each of these contrast agents expires from pass-through status. Table 11 of CR 7271 is as follows:

APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2011

CY 2011 APC	CY 2011 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

Clarification of Coding for Drug Administration Services

CMS revised the *Medicare Claims Processing Manual*, Chapter 4, Section 230.2, to clarify the correct coding of drug administration services. This Manual revision is included as an attachment to CR 7271. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual.

Changes to OPPS Pricer Logic

a. Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (Section 1833(t)(13)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet), as added by Section 411 of Pub. L. 108-173.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2011. All copayments amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2011 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2011. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. However, there will be a change in the fixed-dollar threshold in CY 2011. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2010 was $2,175.

e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2011. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2011, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1749 for new Endoscope, retrograde imaging/illumination colonoscope device (implantable) has an offset amount of $0 because CMS is not able to identify a portion of the APC payment amount associated with the cost of the device. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.

g. Effective January 1, 2011, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2011, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

i. Effective January 1, 2011, there will be two contrast agents receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the "policy-packaged" portions of the CY 2011 APC payments for procedures using contrast agents and may be found on the CMS Web site.

j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k. Effective January 1, 2011, CMS is adopting the Fiscal Year (FY 2011) Inpatient Prospective Payment System (IPPS) post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of Pub. L. 108-173 to non-IPPS hospitals.

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) or 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.

Outpatient Provider Specific File (OPSF)

CR 7271 also provides instructions to Medicare contractor on updating the OPSF.

Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) extends the Outpatient Hold Harmless provision from January 1, 2011, through December 31, 2011, for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs), regardless of bed size, at 85 percent of the hold harmless amount from January 1, 2011, through December 31, 2011. Cancer and children's hospitals are permanently held harmless under Section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive transitional outpatient payments (TOPs)TOPs payments through CY 2011.

For CY 2011, small rural hospitals with 100 or fewer beds and all sole community hospitals (and essential access community hospitals) remain eligible for a TOPS adjustment. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Requirements

Effective for OPPS services furnished on or after January 1, 2009, hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2011, Medicare contractors will maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field.

Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)

As stated in Pub 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 50.1, Medicare contractors maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider CCRs. The file of OPPS hospital upper limit CCRs and the file of statewide CCRs are located at http://www.cms.gov/HospitalOutpatientPPS/ under "Annual Policy Files." A spreadsheet listing the statewide CCRs also can be found in the file containing the preamble tables that appears in the most recent OPPS/ASC final rule.

Additional Information

The official instruction, CR 7271, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2141CP.pdf on the CMS Web site.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252 titled "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0". A Medicare Learning Network (MLN) Matters® article MM7252, which is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7252.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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Smoking and Tobacco-Use Cessation Counseling—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) *Matters* article, "Smoking and Tobacco-Use Cessation Counseling," which was published in the September 1, 2005, *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.gov/MLNMattersArticles/**

MLN Matters Number: MM3834
Related CR Release Date: May 20, 2005
Related CR Transmittal #: 36 and 562

Related Change Request (CR) #: 3834
Effective Date: March 22, 2005
Implementation Date: July 5, 2005

Note: This article was revised on February 24, 2011, to add a reference to MM5878 in the Additional Information section. MM5878 announced replacement codes for the temporary G Codes discussed in this article. All other information remains the same.

Provider Types Affected
Physicians, other Medicare-recognized practitioners, and providers billing Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers for smoking and tobacco-use cessation counseling.

Provider Action Needed
STOP – Impact to You
Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco-use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco-use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco-use as based on FDA-approved information. Patients must be competent and alert at the time that services are provided. Two attempts are covered each year; each attempt may include a maximum of four intermediate or intensive sessions. Maximum 8 sessions in one year are covered.

CAUTION – What You Need to Know
CMS has established two new "G" codes for billing for the new levels of smoking and tobacco-use cessation counseling, effective for dates of service on or after March 22, 2005.

Note: For the interim period of March 22, 2005, through July 4, 2005, when billing for smoking and tobacco-use cessation counseling, use the unlisted code 99199. On and after July 5, 2005, when billing for this counseling, use the appropriate new "G" codes. Include one unit per session in the unit's field of the claim.

GO – What You Need to Do
Make sure your billing staff is aware of the new codes and the interim coding requirements when submitting claims for the smoking and tobacco-use cessation counseling services you provide on or after March 22, 2005.

Based on a 2004 request from the Partnership for Prevention to review the issue for a national coverage determination (NCD), CMS determined that the evidence is adequate to conclude that smoking and tobacco-use cessation counseling, based on current Public Health Service (PHS) guidelines, is reasonable and necessary for certain individuals who use tobacco and have a disease or an adverse health effect caused or complicated by tobacco-use. Patients must be competent and alert at the time that services are provided.

What Is Covered
When certain coverage conditions, frequency and other limitations are met, smoking and tobacco cessation counseling is covered under Medicare Part B. Medicare Part B coverage includes 2 attempts each year. Each attempt may include a maximum of 4 intermediate or intensive sessions. A total of 8 sessions are covered in a 12-month period. The qualified practitioner and the patient have flexibility to choose between intermediate or intensive cessation strategies for each session.

Billing Codes
The following two new Health Common Procedure Coding System (HCPCS) codes have been created for billing for the two new levels of smoking and tobacco-use cessation counseling Medicare now covers:

G0375 - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. Short Descriptor: Smoke/Tobacco counseling 3-10.

G0376 - Smoking and tobacco-use cessation visit; intensive, greater than 10 minutes. Short Descriptor: Smoke/Tobacco counseling greater than 10.

Because these new "G" codes will not be in the Medicare system until July 5, 2005, for the interim period of March 22, 2005, through July 4, 2005, use the unlisted code 99199 when billing for smoking and tobacco-use cessation counseling. Include one unit per session in the units field of the claim. Effective for claims received by Medicare on or after July 5, 2005, the claim should reflect HCPCS codes G0375 or G0376 (effective back to March 22, 2005, the effective date of the new coverage).

Note: Code 99199 is carrier priced. Also, providers whose claims are subject to payment under the Outpatient Prospective Payment System (OPPS) should use the G codes instead of 99199. Such claims will be held by your FI until July 5, at which time they will be processed.

This additional coverage, as described by the above HCPCS codes G0375 and G0376 does not change the existing coverage for minimal cessation counseling (defined as 3 minutes or less in duration) bundled into the normal Evaluation and Management (E/M) visit.

Smoking and tobacco-use cessation counseling claims are to be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco.

Note: Providers are reminded that they should keep on file appropriate documentation in the patient's medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco-use cessation counseling.

Physicians and other Medicare-recognized practitioners who need to bill for E&M services on the same day as smoking cessation services are billed should use the appropriate HCPCS code in the 99201-99215 range AND modifier 25 to show that the E&M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, meaning charges to the beneficiary may be no more than 115% of the allowed amount.

Smoking and tobacco-use cessation counseling services may be billed to FIs and RHHIs on types of bills (TOB) 12X, 13X, 14X, 22X, 23X, 34X, 71X, 73X, 74X, 75X, 83X, and 85X. On TOBs 71X and 73X (Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)), FIs will pay for claims with revenue code 052X. For TOB 13X (Indian Health Service (IHS)), FIs shall accept revenue code 0510. CAH Method II providers should use the appropriate revenue code in the range of 096X through 098X when reporting smoking and tobacco-use cessation counseling services. For other TOBs, on claims received on or after July 5, 2005, FIs and RHHIs will pay for G0375 and G0376 codes when accompanied by revenue code 0942 (other therapeutic services; education/training).

Payment by FIs/RHHIs is as follows:

Type of Facility	Method of Payment
RHCs/FQHCs	All-inclusive rate (AIR) for the encounter
IHS/Tribally owned or operated hospitals and hospital based facilities	AIR
IHS/Tribally owned or operated non-hospital based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated critical access hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled nursing facilities (SNFs) **Note: Included in Part A PPS for skilled patients.**	MPFS
Comprehensive outpatient rehabilitation facilities (CORFs)	MPFS
Home health agencies (HHAs)	MPFS
CAHs	**Method I:** Technical services are paid at 101% of reasonable cost; **Method II:** Professional services are paid at 115% of the MPFS Data Base
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

Additional Information

Note: When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, the services are considered "incident to" and do not constitute a billable visit. In addition, Medicare will not cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

For complete details, please see the official instructions issued to your carrier/FI/RHHI regarding this change, which may be found by going to http://www.cms.gov/Transmittals/downloads/R562CP.pdf and http://www.cms.gov/Transmittals/downloads/R36NCD.pdf on the CMS Web site.

The file with transmittal number 36 will contain the NCD information and the one with transmittal number 562 will contain the changes to Medicare claims processing requirements.

You may want to review MM4104, which announced the implementation (effective April 1, 2006) of the capability for providers to access the Common Working File for viewing the number of smoking and tobacco-use cessation counseling sessions a beneficiary has received. That article may be found at http://www.cms.gov/MLNMattersArticles/downloads/MM4104.pdf on the CMS Web site.

You may also want to review MM5878, which contains information on replacement codes for the temporary G codes discussed in this article. MM5878 is available at http://www.cms.gov/MLNMattersArticles/downloads/MM5878.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, to call the Provider Contact Center.

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News from CMS for Hospice Providers

Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation

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.gov/MLNMattersArticles/**

MLN Matters® Number: MM7337
Related CR Release Date: March 2, 2011
Related CR Transmittal #: R141BP
Related Change Request (CR) #: 7337
Effective Date: January 1, 2011
Implementation Date: March 23, 2011

Provider Types Affected

This article is for 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

CR 7337, from which this article is taken, announces changes/clarifications in the "*Medicare Benefit Policy Manual*", including updates to the hospice Conditions of Participation (CoP) section (related to bereavement, the establishment of the plan of care, personnel requirements, physician contracting requirements, core services, and non-core services), and the certification section, along with some minor technical edits.

You should make sure that these clarifications are incorporated into your care of hospice patients.

Background

Under Section 1861(dd) of the Social Security Act (the Act), the Secretary of Health and Human Services is responsible for ensuring that the Conditions of Participation (CoP), and their enforcement are adequate to protect the health and safety of individuals under hospice care. The hospice CoPs were originally published

in the Federal Register on December 16, 1983, (48 FR 56008), and were amended on December 11, 1990, (55 FR 50831) largely to implement provisions of Section 6005(b) of the Omnibus Budget Reconciliation Act of 1989; revised CoPs were published in the June 5, 2008, Hospice Conditions of Participation Final Rule (73 FR 32088).

The August 6, 2009, Hospice Wage Index Final Rule (74 FR 39384) required that certifications and re-certifications include a brief narrative describing the clinical basis for the patient's prognosis.

Finally, with passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice Nurse Practitioners (NPs) to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. CMS implemented the policies related to this new requirement (which became effective on January 1, 2011) in the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372).

CR 7337, from which this article is taken, announces that Chapter 9 (Coverage of Hospice Services Under Hospital Insurance) of the "*Medicare Benefit Policy Manual*" is being revised to include the existing policies described above (which were implemented through notice-and-comment rulemaking), and to make a few technical corrections to the manual.

The manual revisions are attached to CR 7377, which is available at http://www.cms.gov/Transmittals/downloads/R141BP.pdf on the CMS Web site. A synopsis of the major manual revisions and technical edits is as follows:

MANUAL REVISIONS

- **Section 20.1 (Timing and Content of Certification)**
  Initial certifications may be completed up to 15 days before hospice care is elected, and for the subsequent periods, re-certifications may be completed up to 15 days before the next benefit period begins.

  In addition, as of October 1, 2009, physicians must briefly synthesize the clinical information supporting the terminal diagnosis in a narrative, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The certifications or recertifications must be signed and dated by the physician(s), and provide the benefit period dates that the certification or recertification covers.

  The physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.

  The narrative must be included as part of the certification and recertification forms, or as an addendum to the certification and recertification forms. If the narrative is part of the certification or recertification form, it must be located immediately above the physician's signature, or if it is an addendum to the certification or recertification form, (in addition to the physician's signature on the certification or recertification form), the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.

For recertifications on or after January 1, 2011, a hospice physician or hospice Nurse Practitioner (NP) must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's 3rd benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement, and the patient would cease to be eligible for the benefit.

Also for recertifications on or after January 1, 2011, the narrative associated with the 3rd benefit period recertification (and every subsequent recertification) must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

The face to face encounter must meet the following criteria:

1. Timeframe - The encounter must occur no more than 30 calendar days prior to the start of the 3rd benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter; except as noted in item 4 below.
2. Attestation requirements - A hospice physician or Nurse Practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.
3. Practitioners who can perform the encounter - A hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice, however a hospice Nurse Practitioner must be employed by the hospice. (A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.)
4. Timeframe for Exceptional Circumstances - In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face-to-face encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a face to face encounter, a face to face encounter can be deemed as complete.

- **Section 40.2.3 – Bereavement Counseling**
  Bereavement counseling consists of counseling services provided to the individual's family both before and after the individual's death.

- **Section 40.3 Physician Contracting**
  A hospice may contract for physician services as specified in the CoPs. The hospice medical director must supervise all physician employees, as well as those under contract.

- **Section 40.4 (Core Services)**
  The following are hospice core services:
  - Physician services;
  - Nursing services, (routinely available and/or on call on a 24-hour basis, 7 days a week) provided by or under the supervision of a Registered Nurse (RN) functioning within a plan of care developed by

the hospice Interdisciplinary Group (IDG) in consultation with the patient's attending physician, if the patient has one;

- Medical social services by a qualified social worker under the direction of a physician; and
- Counseling (including, but not limited to, bereavement, dietary, and spiritual counseling) with respect to care of the terminally ill individual and adjustment to death. (The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to 1 year following the death of the patient.)

Except for physician services, your employees must routinely provide substantially all of the core services, and in a manner consistent with acceptable standards of practice. However, under extraordinary or other non-routine circumstances, you may use contracted staff (if necessary) to supplement your employees in order to meet patients' needs. Arranged services must be supported by written agreements that require that all services be: 1) Authorized by the hospice; 2) Furnished in a safe and effective manner by qualified personnel; and 3) Delivered in accordance with the patient's plan of care. To ensure the provision of quality care, the hospice must retain administrative and financial management, and oversight of all arranged staff and services.

Highly Specialized Nursing Services

You may contract for the services of a registered nurse if the services are highly specialized and provided non-routinely, and so infrequently that the direct provision of such services would be impracticable and prohibitively expensive. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service. For example, you may need to contract with a pediatric nurse if you care for pediatric patients infrequently and if employing a pediatric nurse would be impracticable and expensive.

NOTE: Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.

Waivers for Certain Circumstances

Hospices are prohibited from contracting with other hospices and non-hospice agencies for the provision of the core services of nursing, medical social services and counseling to hospice patients; but may enter into arrangements with another hospice program or other entity for the provision of these core services in extraordinary, exigent, or other non-routine circumstances.

An extraordinary circumstance would generally be an unanticipated, short-term, temporary event such as periods of high patient loads, caused by an unexpectedly large number of patients requiring continuous care simultaneously, temporary staffing shortages due to illness, receiving patients evacuated from a disaster such as a hurricane or a wildfire, or temporary travel of a patient outside the hospice's service area.

You must maintain evidence of the extraordinary circumstances that required you to contract for the core services and comply with the following:

1. You must ensure that contracted staff is providing care that is consistent with the hospice philosophy and the patient's plan of care and is actively participating in the coordination of all aspects of the patient's hospice care;
2. You may not routinely contract for a specific level of care (e.g., continuous care) or for specific hours of care (e.g., evenings and week-ends); and
3. You must maintain professional management responsibility for all services provided under arrangement or contract at all times and in all settings.

Waiver for Certain Core Nursing Services

The CoPs allow CMS to waive the requirement that a hospice provide nursing services directly, if you are located in a non-urbanized area (as determined by the Bureau of the Census). In seeking this waiver, you must provide evidence to CMS that you have made a good faith effort to hire enough nurses to provide services.

NOTE: The location of a hospice that operates in several areas is considered to be the location of its central office.

- **Section 40.5 (Non-Core Services)**

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), you must also provide the following services, either directly or under arrangements, to meet the your patients' and their families' needs:

- Physical and occupational therapy and speech-language pathology services;
- Hospice aide services - A hospice aide employed by a hospice, either directly or under contract, must meet the qualifications required by Section 1891(a)(3) of the Social Security Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1891.htm) and implemented at 42CFR418.76;
- Homemaker services;
- Volunteers;
- Medical supplies (including drugs and biologicals on a 24-hour basis) and the use of medical appliances related to the terminal diagnosis and related conditions; and
- Short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility.

Section 1861(dd)(5) of the Social Security Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm) allows CMS to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling available (as needed) on a 24-hour basis. CMS is also allowed to waive the requirement that hospices provide dietary counseling directly.

As with the waivers mentioned in the section above, these are available only to an agency or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel.

MANUAL TECHNICAL EDITS

The following edits to the manual are not policy changes, but rather are technical corrections to manual sections that were either outdated or incorrect:

- Language from 42 CFR 418.24 was added to Section 20.2 to note that in electing the hospice benefit, the patient should have a full understanding of the palliative rather than curative nature of the treatment;
- Language in Section 40.1.2 that referred to the "treatment of the patient's medical condition or to the patient's rate of recovery" was removed and replaced with language referring to the "palliation and management of the patient's terminal illness and related conditions;" and two references to the patient's recovery were removed;
- Policy in Section 40.1.9 describing ambulance transports which occur on the effective date of election was clarified to note that the transports must be to the patient's home to be covered by the ambulance benefit;

- Example 1.B in Section 40.2.1 was corrected to increase the hours of continuous care provided by a nurse, so that the total Continuous Home Care (CHC) hours were predominantly nursing hours, in keeping with existing CHC policy;
- Outdated language related to the establishment of the plan of care was removed; and
- Terminology was updated throughout the manual, as home health aides are now known as hospice aides, and Licensed Vocational Nurses (LVNs) were not previously mentioned.

Additional Information

You can find more information about the updates to the Hospice Benefit Policies by going to CR 7337, located at http://www.cms.gov/Transmittals/downloads/R141BP.pdf on the CMS Web site. You can find the updated "*Medicare Benefit Policy Manual*," Chapter 9 as an attachment to that CR.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site and select "Phone Us" under the "Home Health & Hospice (HH+H)" heading, 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. CPT only copyright 2011 American Medical Association.

News from Cahaba for Home Health and Hospice Providers

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 **April 30, 2011**, for the quarter ending **March 31, 2011**.

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:

Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA
P.O. Box 14537
Des Moines, IA 50306-3537

If sending overnight:
Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA
400 East Court Avenue, Suite 400-D
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**.

Provider Contact Center Availability

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 are the training dates and times for our home health and hospice PCC Customer Service Representatives training sessions.

CSR Training Date	Time
April 12, 2011	8:20 a.m.—10:40 a.m. Central Time
May 10, 2011	8:20 a.m.—10:40 a.m. Central Time

The Interactive Voice Response (IVR) remains available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. You may also refer to the "Resources for the Most Common Home Health and Hospice Medicare Questions" Web page and the HH+H "Frequently Asked Questions" Web page for assistance.

News from Cahaba for Home Health Providers

Update to Local Coverage Determination (LCD): Physical Therapy – Home Health (L23604)

Effective April 1, 2011, the Local Coverage Determination (LCD) **Physical Therapy – Home Health (L23604)** is being updated.

The following revisions are being made to the LCD based on the Home Health Prospective Payment System Rate Update for Calendar Year 2011 published in the Federal Register on November 17, 2010:

- The *Documentation Requirements* are being updated; and
- In the *Indications and Limitations of Coverage and/or Medical Necessity* section, the third bullet under 'Indications' is being updated.

Providers are encouraged to review this LCD 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.

April 2011 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.

- **"Medicare Secondary Payer (MSP) Adjustments Lunch & Learn" Webinar**
  Date: April 14, 2011
  Time: 12:00 – 1:00 p.m. Central Time
  Registration Deadline: April 11, 2011
  Intended Audience: Home health and hospice billers, administrators and financial staff
  Description: This event will focus on adjusting claims that have rejected due to an open MSP record at the Common Working File (CWF). You will learn how to identify claims rejected for MSP, as well as the appropriate billing and submission of the adjustment claim for Medicare payment, including all required MSP and adjustment data elements.

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

- **"Online Courses"** are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone. **Please note** these courses were designed specifically for providers served by Cahaba. You can find additional national courses under the *Medicare Learning Network*.

- **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.