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Physician Orders for Laboratory/Diagnostic Tests

Recent assessments from the Comprehensive Error Rate Testing (CERT) Program for Pennsylvania Medicare Part A & Part B indicate egregious errors for missing physician orders in the patient medical records. CERT is assessing the Carriers/Fiscal Intermediaries medically unnecessary service/treatment errors because either:

- ◆ the beneficiary's medical record lacks a copy of a physician order, or;
- ◆ a notation for laboratory/diagnostic tests is not in the beneficiary file from either the **physician's office** or the **testing facility**.

Please remember, it is the responsibility of the ordering or treating physician or practitioner to maintain a signed and dated order for the beneficiary or to document the order in the beneficiary's medical record. The medical reason for the

order must also be present in the medical record. The testing facility should retain a copy of the signed and dated order or notation of the order.

An "**order**" is a request from the treating physician/practitioner for a beneficiary to receive a laboratory or diagnostic test. The order may include a 'conditional' request for additional lab/diagnostic tests if the result of the initial test yields a certain value (i.e., if test X is negative, then perform test Y). A **diagnostic test** includes all diagnostic radiology tests, imaging, ultrasounds and lab tests.

An order may be communicated by:

- ◆ A written document signed by the treating physician or practitioner, which is hand delivered, mailed or faxed to the testing facility;

- ◆ A telephone call* by the treating physician/practitioner or his or her office to the testing facility;
- ◆ An electronic mail* by the treating physician/practitioner or his or her office to the testing facility.

*If the **order** is communicated by phone or e-mail the physician office and testing facility must make a note of the 'order' in the beneficiary's medical record.

A **treating physician** is a physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results of the diagnostic tests in the management of the beneficiary's specific medical problem.

A **radiologist** performing a therapeutic interventional procedure is considered a treating physician.

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our website.

Physician Orders for Laboratory/Diagnostic Tests

A **radiologist** performing a diagnostic interventional or diagnostic procedure is **not** considered a treating physician.

A **treating practitioner** is a nurse practitioner, clinical nurse specialist or physician assistant, who furnishes,

according to State law, a consultation or treats a beneficiary for a specific medical problem and who uses the results of the diagnostic tests in the management of the beneficiary's specific medical problem.

A **testing facility** is a Medicare provider or supplier that furnishes diagnostic tests. A testing facility may include a physician or a group of physicians (e.g., radiologist, pathologist), a laboratory, or an independent diagnostic testing facility (IDTF).

Update on the Progressive Corrective Action (PCA) Service Wide Review for Sleep Disorder Testing (PA Providers)

The purpose of this notice is to update the Pennsylvania provider community of issues surrounding the Progressive Corrective Action (PCA) service wide review for Sleep Disorder testing conducted by Highmark Medicare Services and to remind providers of the indications and limitation of coverage and/or medical necessity guidelines for Sleep Disorder Testing. This notice is also intended to assist in decreasing the paid claims error rate and to avoid provider denials of the above listed services.

The information provided is based on claims submitted and reviewed for Sleep Disorder Testing from November 16, 2007 through May 15, 2008.

At this time the paid claims error rate for Sleep Disorder Testing is 51%. Compared to the 22% error rate for

claims reviewed from May 1, 2007 through November 15, 2007, the current review of claims shows an increase in the paid claims error rate of 29%. The majority of claim denials were due to insufficient documentation to support the indications and medical necessity for sleep disorder testing per Medicare guidelines as well as documentation to support the need for CPAP titration per Medicare guidelines. Claims for diagnostic testing only or split night testing did not include a physician's history and physical or documentation to support the need for testing confirmed by medical evidence including a thorough sleep history. Claims for Polysomnography with CPAP titration did not include results of the initial/diagnostic testing in order to support medical necessity of the titration per Medicare guidelines.

Due to the significantly elevated error rate, the Progressive Corrective Action for Sleep Disorder Testing will continue.

Please refer to the following references for additional information:

[Local Coverage Determination Z-8L](#), Sleep Disorder Testing

[National Coverage Determination \(NCD\) 240.4](#), Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)

Frequently Asked Questions (FAQ's): [Diagnostic Testing for Sleep Disorders](#).

SNF Medical Review Letters

Effective for claims reviewed 06/02/08 and after, Highmark Medicare Services will no longer mail letters to Skilled Nursing Facilities (SNF) after each claim review. Providers are reminded that information regarding claim adjudication is available to them through the Fiscal Intermediary Standard System (FISS). To access this information you may:

- ◆ Access option 12 (claims) through FISS. On page 2, key F9 twice and then you will see the line item denial reason code. Note the reason code that begins with a 5, key F1 and type in the reason code with the 5 for a detailed description.
- ◆ Access option 12 (claims) through FISS. On page 4, a brief description of the denial will be available.
- ◆ View your remittance advice for ANSI codes which will explain the denial.

New Contractor Numbers for the J12 MAC Contractors Part A and Part B Workloads for the States of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia

The purpose of this notice is to notify all interested parties that the Centers for Medicare and Medicaid Services (CMS) needs to change the contractor numbers in the Medicare Administrative Contractor (MAC) Jurisdiction 12 for the Part A and Part B workloads in the states of Delaware, Maryland, New Jersey, Pennsylvania, and the District of Columbia when those areas become live in Jurisdiction 12. These changes need to be made because certain applications require separate contractor numbers for each state. Part A and Part B claims for those states will be processed by the Jurisdiction 12 MAC using the contractor numbers and effective dates listed below.

PART A	MAC Workload No.	Effective Date	Current Contractor No.
Delaware	12101	11/14/2008	00308
District of Columbia	12201	08/01/2008	00366
Maryland	12301	08/01/2008	00366
New Jersey	12401	09/01/2008	00390
Pennsylvania	12501	08/01/2008	00363

PART B	MAC Workload No.	Effective Date	Current Contractor No.
Delaware	12102	07/11/2008	00902
District of Columbia Metropolitan Area*	12202	07/11/2008	00903
Maryland	12302	07/11/2008	00901
New Jersey	12402	11/14/2008	00805
Pennsylvania	12502	12/12/2008	00865

*The Part B providers and workload for the District of Columbia Metropolitan Area (DMCA), including the northern Virginia area, will be transitioned in its entirety to Highmark Medicare Services as part of the J12 MAC workload implementation. The "DCMA" is defined as the District of Columbia, Prince Georges (MD) County, Montgomery (MD) County, Arlington (VA) County, Fairfax (VA) County, and the City of Alexandria (VA).

EDI billers can find additional information on how to use these new workload numbers on the Highmark Medicare Services web site, at the following address: <http://www.highmarkmedicare.com/transition/j12/edi-systems-index.html>

Hardcopy Claims - Reminder for All MD/DC Providers

This notice serves as a reminder to all MD/DC providers. Hardcopy/paper claims must be submitted to the Camp Hill mailing address. Highmark Medicare Services must image every hardcopy/paper claim submitted, when a claim is not submitted to the designated address, processing delays will occur. In addition, Highmark Medicare Services Maryland office will be relocating and the Timonium address will no longer be valid. If you do not utilize the designated PO Box for your hardcopy/paper claims, **your claims will be returned**. The designated address for submission of hardcopy/paper claims for all MD/DC providers is:

Highmark Medicare Services
Attn: Claims Department
P.O. Box 890386
Camp Hill, PA 17089-0386

Update on the Skilled Nursing Facility High Rehabilitation RUG Categories for (PA Providers)

The purpose of the article is to inform the Skilled Nursing Facility (SNF) community of issues surrounding the service wide edit regarding the ultra and very high rehabilitation categories which was initiated in July 2006.

The information provided is based on claims submitted and reviewed for Ultra High and Very High Rehabilitation from November 1, 2007 through April 30, 2008.

At this time the paid claims error rate for the Ultra High and High Rehabilitation RUGS is **24%**. Compared to the **27%** error rate for claims reviewed from May 1, 2007 through October 31, 2007, the current review of claims shows a **decrease** in the paid claims error rate of **3%**.

Section 4432 (b) of the Balanced Budget Act (BBA) of 1997 modified how Medicare payments are made to SNFs. Effective with cost reporting periods beginning on or after July 1, 1998, Medicare began paying SNFs on the basis of a Prospective Payment System (PPS). Fiscal Intermediaries (FIs) are required to conduct audits of providers' records as needed to ensure that payments made are accurate. It is under this authority that the following medical review guidelines are being implemented.

General Medical Review Guidelines

PPS payments are per diem rates based on the patient's condition as determined by classification into a specific Resource Utilization Group (RUG). This classification is made by using the Minimum Data Set (MDS).

Medical review decisions are based on the Look Back Periods relevant to the MDS(s), information entered in the Minimum Data Set Quality Control (MDS QC) System Software, and sup-

porting documentation for the claim period billed.

Under PPS, beneficiaries must continue to meet the regular eligibility requirements for a SNF stay (e.g., 3-day medically necessary hospital stay, transfer to a participating SNF within 30 days after discharge from the hospital, and the services must be for treatment of a condition for which the beneficiary was treated in the hospital or one that arose during the qualifying hospital stay)

Under PPS the beneficiary must continue to meet level of care requirements as defined in [42 CFR § 409.31](#).

In order for the contractor to determine upon medical review if the beneficiary was correctly assigned to a RUG-III group, supporting documentation must be submitted. This documentation includes the MDS, physician, nursing, and therapy documentation. This documentation must be for the dates of service requested on the Additional Development Request (ADR) as well as the Look Back Period.

Ultra High and Very High Rehabilitation RUGS Edit Summary:

A service wide review was conducted on claims randomly selected from all SNF providers.

The majority of the full and partial denials were related to insufficient documentation, i.e., absence of medical documentation for services provided during the Look Back Period.

If rehabilitation services are warranted, but do not meet the requirements of the RUG code, then adjustments must be made to the billed RUG-III code, i.e., total treatment minutes do not meet the level of rehabilitation billed.

Insufficient documentation indicates that the information requested as per the Additional ADR was not sent with the medical record. The ADR generated for Skilled Nursing Facilities is specific to the documentation required for review and details what should be provided when the information is requested. The information requested on the SNF ADR is listed below:

Providers should send the following information for **dates of service** requested as well as the **look back period**:

1. Certification/ Recertification
2. Physician's Orders and Progress Notes
3. Nurses Notes
4. All MDS Assessments to support these service dates
5. Documentation to fully support each MDS
6. Medication and Treatment Records
7. If applicable, records for physical therapy, occupational therapy, speech therapy, and decubitus ulcer records including:
 - a. Initial evaluation
 - b. Therapy progress notes
 - c. Treatment records to verify treatment plan, goals and therapy minutes
 - d. Therapy minutes to support RUG assessment if outside billed dates of service
8. Hospital records to support the qualifying stay. These should include: Transfer sheet, History and Physical, Discharge Summary and Surgical Report (if applicable).

Update on the Skilled Nursing Facility High Rehabilitation RUG Categories for (PA Providers)

continued from page 4

It is very important that providers contact third parties such as other providers, health care facilities, or suppliers and request a copy of the medical documentation necessary to fully support the services billed to Medicare. It is the responsibility of the provider submitting the claim for payment to obtain all the requested documentation, regardless of where the records are kept.

If the SNF is unable to obtain formal reports from the hospital provider, it would be expected that the necessary information be evidenced in the clinical record as part of a communication between the SNF and the hospital provider. All information submitted is reviewed for content regardless of format.

Please have your staff ensure that all the requested information on the ADR is included in the package before sending it to Highmark Medicare Services. Please be sure a copy of the ADR letter is on the top of the set of documents being sent.

In summary, when claims for Skilled Nursing Facilities are presented to the Highmark Medicare Services Medical Review Department, the documentation will be reviewed to determine if the records support the RUGs code billed. Medicare Program Integrity Manual, Pub 100-8, Chapter 6 Intermediary MR Guidelines for Specific Services, Section 6.1.3, Bill Review Process, describes medical necessity for Skilled Nursing Facilities.

References

- ◆ Highmark Medicare Services FAQs
- ◆ CMS RAI Manual
- ◆ CMS - Chapter 6 of the RAI Manual, MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)
- ◆ CMS Medical Policy Internet Only Manuals 100-08, Chapter 6 Intermediary MR Guideline for Specific Services

Assistance

If you have any questions regarding this notice please contact the Customer Contact Center for your area at:

- ◆ MD/DC Providers: 1-866-488-0545
- ◆ PA Providers: 1-800-560-6170

Implementation of the 2007-2008 update to the Medicare Wage Index Occupational Mix Survey (Form CMS-10079 (2008))

Section 304 (c) of Public Law 106-554 amended Section 1886(d)(3)(E) of the Act requiring the Centers for Medicare and Medicare Services (CMS) to collect data at least every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, beginning October 1, 2004.

CMS collects data for the occupational mix adjustment on the Medicare Wage Index Occupational Mix Survey, Form CMS-10079. Data from the 2006 update (CR#3043) were used to calculate the FYs 2007, 2008, and 2009 wage index. In order to comply with the statutory requirement, we are

administering a new survey, the 2007-2008 update, to be used in computing the wage index beginning with FY 2010.

On February 2, 2007, CMS published a notice of intent with comment regarding a new occupational mix survey (72 FR 5055). This new survey is the 2007-2008 Medicare Occupational Mix Survey (Form CMS-10079 (2008)). The final notice with comments was published on September 14, 2007 (72 FR 52568). The 2007-2008 survey provides for the collection of hospital-specific wages and hours data for a 1-year prospective reporting period (that is, from July 1, 2007 through June 30, 2008), additional clarifications to the survey instruc-

tions, the elimination of the RN sub-categories, some refinements to the definitions for the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The survey and supporting documentation can be accessed through CMS's web site at: <http://www.cms.hhs.gov/PaperWorkReductionActof1995> .

The Office of Management and Budget approved the survey on February 1, 2008 (OMB Control Number: 0938-0907).

[Complete Transmittal R339OTN \(CMS\)](#)

[2007-2008 Hospital Form CMS-10079 OM Survey \[ZIP, 69KB\]](#)

MLN Matter Articles

Provider Authentication by Medicare Provider Contact Centers

MLN Matter Number: SE0814	Related Change Request (CR) #: n/a
Related CR Release Date: n/a	Effective Date: n/a
Related CR Transmittal #: n/a	Implementation Date: n/a

SE0814 covers the implementation of the National Provider Identifier (NPI) and the Provider Transaction Access Number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

Prolonged Services (Codes 99354 - 99359)

MLN Matter Number: MM5972	Related Change Request (CR) #: 5972
Related CR Release Date: April 11, 2008	Effective Date: July 1, 2008
Related CR Transmittal #: R1490CP	Implementation Date: July 7, 2008

CR 5972, from which this article is taken, updates the sections of the Medicare Claims Processing Manual that address prolonged services codes, in order to be consistent with changes/deletions in codes and changes in typical/average time units in the American Medical Association Current Terminology Procedural Terminology (CPT) coding system.

Ambulance Fee Schedule - Conversion Factor File for CY 2009 Ambulance Inflation Factor

MLN Matter Number: MM6000 - Revised	Related Change Request (CR) #: 6000
Related CR Release Date: May 2, 2008	Effective Date: January 1, 2008
Related CR Transmittal #: R1499CP	Implementation Date: October 6, 2008

This article is based on Change Request (CR) 6000, which revises the ambulance fee schedule file layout for Calendar Year (CY) 2009.

Note: This article was revised on May 6, 2008, to correct the implementation date of the instruction. That date is October 6, 2008. All other information remains the same.

Adjusting Inpatient Prospective Payment System (IPPS) Reimbursement for Replaced Devices Offered Without Cost or With a Credit

MLN Matter Number: MM5860 - Revised	Related Change Request (CR) #: 5860
Related CR Release Date: May 16, 2008	Effective Date: October 1, 2008
Related CR Transmittal #: R1509CP	Implementation Date: October 6, 2008

This article is based on Change Request (CR) 5860 which provides instructions for billing replaced devices that are received without cost or with a credit. It also includes Medicare contractor instructions for how to reduce the IPPS payment based on the amount of the credit received by the hospital for the replaced device.

Note: This article was revised on May 19, 2008, to show that the Transmittal 1498 for this Change Request was replaced with Transmittal 1509 on May 16, 2008. The web address for the transmittal was also changed. All other information remains the same.

Billing Blood and Blood Products

MLN Matter Number: MM5867	Related Change Request (CR) #: 5867
Related CR Release Date: May 2, 2008	Effective Date: October 1, 2008
Related CR Transmittal #: R1495CP	Implementation Date: October 6, 2008

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5867 to clarify for providers that:

- ◆ Medicare does not pay for the first three units of whole blood or packed red cells that are furnished under Part A or Part B in a calendar year.
- ◆ The Part B blood deductible is reduced to the extent that it has been met under Part A, and vice versa.
- ◆ The blood deductible does not apply to the costs of processing, storing, and administering blood.
- ◆ To meet the blood deductible, beneficiaries have the option of paying the hospital's charges for the blood or packed red cells or arranging for it to be replaced.
- ◆ Beneficiaries are not responsible for the blood deductible if the provider obtained the whole blood or packed red cells at no charge other than the processing charge.

MLN Matter Articles (continued)

Blood-Derived Products for Chronic, Non-Healing Wounds

MLN Matter Number: MM6043	Related Change Request (CR) #: 6043
Related CR Release Date: May 2, 2008	Effective Date: March 19, 2008
Related CR Transmittal #: R83NCD	Implementation Date: June 2, 2008

This article is based on Change Request (CR) 6043 which provides the Centers for Medicare & Medicaid Services (CMS) updated policy regarding autologous blood-derived products for chronic, non-healing wounds.

Reporting of Additional Data to Describe Services on Hospice Claims

MLN Matter Number: MM5567 - Revised	Related Change Request (CR) #: 5567
Related CR Release Date: April 29, 2008	Effective Date: January 1, 2008 (optional); July 1, 2008 (mandatory)
Related CR Transmittal #: R1494CP	Implementation Date: January 7, 2008

Note: This article was revised on May 1, 2008, to reflect that CMS revised CR5567 to suspend temporarily the reporting of visit data from non-hospice staff in contract facilities providing General Inpatient Care. Also, the CR transmittal date, transmittal number, and Web address for accessing CR5567 were changed. These changes were made as CMS re-issued CR5567 on April 29, 2008. All other information remains the same.

Incident to Policy Update

MLN Matter Number: MM5288 - Revised	Related Change Request (CR) #: 5288
Related CR Release Date: May 2, 2008	Effective Date: June 2, 2008
Related CR Transmittal #: R87BP	Implementation Date: June 2, 2008

CR 5288, from which this article is taken, clarifies current Medicare policy regarding services provided as incident to the services of physicians or nonphysician practitioners (NPP) in the office. Specifically, it updates information in the Medicare Benefit Policy Manual (Chapter 15 -- Covered Medical and Other Health Services, Sections:

- ◆ 50.3 - Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered;
- ◆ 60 - Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service;
- ◆ 60.1 - Incident To Physician's/NPP's Professional Services in Office or Physician/NPP Owned and Operated Clinic;
- ◆ 60.2 - Services of Nonphysician Personnel Furnished Incident To Physician's Services; and
- ◆ 60.3 - Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics)

Note: This article was revised on May 16, 2008, to clarify the language in 4th bullet on page 3 (in bold). That statement should have stated "**..services are provided in a home or in a skilled nursing facility.**" All other information remains

MLN Matter Articles (continued)

Therapy Personnel Qualifications and Policies Effective January 1, 2008

MLN Matter Number: MM5921	Related Change Request (CR) #: 5921
Related CR Release Date: May 7, 2008	Effective Date: January 1, 2008
Related CR Transmittal #: R88BP	Implementation Date: June 9, 2008

CR 5921, from which this article is taken, provides guidance for new regulations (See the Federal Register of November 27, 2007 for the discussion in the Medicare Physician Fee Schedule (MPFS) final rule of 2008.) that address outpatient therapy services, including personnel qualifications and the timing of recertification of plans of care for Part B ser-

Medicare Shared Systems Modifications Necessary to Capture and Crossover Medicaid Drug Rebate Data Submitted on Form UB 04 Paper Claims and Direct Data Entry (DDE) Claims

MLN Matter Number: MM5950	Related Change Request (CR) #: 5950
Related CR Release Date: May 2, 2008	Effective Date: October 1, 2008
Related CR Transmittal #: R1406	Implementation Date:

The Centers for Medicare & Medicaid Service (CMS) issued Change Request (CR) 5950 so that Medicaid drug rebate information submitted to Medicare on the UB 04 or via DDE will crossover to Medicaid. This change request is to notify providers that modifications to Medicare systems will be implemented that will allow CMS to capture and crossover the National Drug Codes (NDCs). Corresponding quantities are then recorded on claims by Medicare providers. In order to capture the information needed to fulfill the rebate requirements, **providers billing for dual eligible patients will be required to submit the NDCs for physician-administered drugs in the Revenue Description Field (Form Locator 43) on the UB-04 in order that this data can be crossed over to Medicaid for the billing of Medicaid rebates.**

July Quarterly Update to 2008 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

MLN Matter Number: MM6009	Related Change Request (CR) #: 6009
Related CR Release Date: May 9, 2008	Effective Date: January 1, 2008
Related CR Transmittal #: R1501CP	Implementation Date: July 7, 2008

This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS). CR 6009 adds HCPCS code J9303 (Injection, Panitumumab, 10MG) to the Major Category III.A. Chemotherapy services FI/A/B MAC Exclusion List retroactive to January 1, 2008.

MLN Matter Articles (continued)

Assignment of Providers to Medicare Administrative Contractors

MLN Matter Number: MM5679	Related Change Request (CR) #: 5679
Related CR Release Date: April 18, 2008	Effective Date: May 19, 2008
Related CR Transmittal #: R333OTN	Implementation Date: May 19, 2008
This "One Time Notice" CR describes the Centers for Medicare & Medicaid Services (CMS) approach for assigning providers to MACs and discusses the process of moving providers to MACs.	

Correction to Determinations of Early Episodes versus Later Episodes under the Home Health Prospective Payment System (HHPPS)

MLN Matter Number: MM6027 - Revised	Related Change Request (CR) #: 6027
Related CR Release Date: May 16, 2007	Effective Date: HHPPS Episodes beginning on or after Jan. 1, 2008
Related CR Transmittal #: R1505CP	Implementation Date: October 6, 2008
Note: This article was revised on May 27, 2008, to revise the effective and implementation dates (see above). All other information remains the same.	
This article is based on Change Request (CR) 6027 which corrects Medicare system determinations of 'early' versus 'later' episodes under the Home Health Prospective Payment System (HH PPS).	

Medical and Other Health Services Furnished to SNF Patients

MLN Matter Number: MM5991	Related Change Request (CR) #: 5991
Related CR Release Date: May 16, 2008	Effective Date: June 16, 2008
Related CR Transmittal #: R89BP	Implementation Date: June 16, 2008
This article is based on Change Request (CR) 5991 which revises the Medicare Benefit Policy Manual (Chapter 8, Section 70) to clarify coverage of Part B services paid in SNFs, including outpatient physical therapy services, outpatient occupational therapy services, and outpatient speech pathology services.	

MLN Matter Articles (continued)

New Chapter in Medicare Claims Processing Manual for Independent Diagnostic Testing Facilities (IDTF)

MLN Matter Number: MM5815	Related Change Request (CR) #: 5815
Related CR Release Date: May 16, 2008	Effective Date: June 16, 2008
Related CR Transmittal #: R1504CP	Implementation Date: June 16, 2008

Change Request (CR) 5815 alerts providers to the fact that information from the Medicare Program Integrity Manual, Chapter 10, regarding claims processing instructions for IDTF's is being excerpted and added to Medicare Claims Processing Manual via Chapter 35 — a new chapter in the Medicare Claims Processing Manual. Currently, the Medicare Claims Processing Manual does not have claims processing instructions for IDTFs and this CR notifies providers of the availability of this information in that manual. No changes in policy are conveyed in CR5815.

Revisions to the Billing Requirements for ESRD-Related Epoprotein Alfa (EPO) and Darbepoetin Alfa (Aranesp) Administrations Provided During Unscheduled or Emergency Dialysis Treatments in the Outpatient Hospital Setting

MLN Matter Number: MM6047	Related Change Request (CR) #: 6407
Related CR Release Date: May 16, 2008	Effective Date: October 1, 2008
Related CR Transmittal #: R1503CP	Implementation Date: October 6, 2008

This article is based on Change Request (CR) 6047 which revises the billing of End Stage Renal Disease (ESRD) related Epoprotein Alfa (EPO) and Darbepoetin Alfa (Aranesp) administrations provided during unscheduled or emergency dialysis treatment in an outpatient hospital setting.

Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents (ESAs), Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs

MLN Matter Number: MM5699 - Revised	Related Change Request (CR) #: 5699
Related CR Release Date: January 11, 2008	Effective Date: January 1, 2008
Related CR Transmittal #: R1412CP	Implementation Date: April 7, 2008

Note: This article was revised on May 16, 2008, to delete the words "decimal implied" in the third bullet item on page 3 that discusses reporting of the MEA segment. The values for the most recent numeric test result should be reported with decimals. All other information remains the same.

MLN Matter Articles (continued)

Adjusting Inpatient Prospective Payment System (IPPS) Reimbursement for Replaced Devices Offered Without Cost or With a Credit

MLN Matter Number: MM5860 - Revised	Related Change Request (CR) #: 5860
Related CR Release Date: May 16, 2008	Effective Date: October 1, 2008
Related CR Transmittal #: R1509CP	Implementation Date: October 6, 2008

Note: This article was revised on May 19, 2008, to show that the Transmittal 1498 for this Change Request was replaced with Transmittal 1509 on May 16, 2008. The web address for the transmittal was also changed. All other information remains the same.

Request for Education

Training and education is paramount to the overall success of administering the Medicare program. Our objectives are to inform and educate our customers through workshops, classes, teleconferences, and online training.

Highmark Medicare Services is committed to educating healthcare professionals and their staff about the:

- Comprehensive Error Rate Testing (CERT) Program
- Rehabilitation Services
- Outpatient Hospital Billing and Coding
- Skilled Nursing Facility Billing and Coding
- Significant changes to the Medicare program

A Highmark Medicare Services Education Specialist will bring the program to you when you provide the facility with at least 15 attendees.

Complete the fields below and click Submit. An Education Specialist will contact you within 15 business days. You can also print this form and mail it to the following address:

Outreach & Education 1BL2
 Highmark Medicare Services
 PO Box 890089
 Camp Hill, PA 17089-0089

You can also visit our website and send us your request [electronically](#).







Name:	Facility Name:
Provider Number:	Phone Number: ()
Email Address:	
Topic(s) Requested for Education:	

Calendar of Events

For: June 2008

- * 06-03-08: [Ask the Contractor Teleconference](#)
1:00 - 2:30 PM
- * 06-10-08: [Basic FISS](#)
Camp Hill, PA
9:00 AM - 12:00 PM
- * 06-11-08: [Basic FISS](#)
Pittsburgh, PA
9:00 AM - 12:00 PM
- * 06-17-08: [CORF/CR 5898 Webinar](#)
10:00 - 11:00 AM
- * 06-20-08: [Outpatient Hospital Services Workshop](#)
Hagerstown, MD
9:00 AM - 12:00 PM
- * 06-27-08: [Outpatient Hospital Services Workshop](#)
Doylestown, PA
9:00 AM - 12:00 PM

JUNE 2008

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3 	4	5	6	7
8	9	10 	11 	12	13	14
15	16	17 	18	19	20 	21
22	23	24	25	26	27 	28
29	30					

Local Coverage Determination (LCDs) Website Links

The following Highmark Medicare Services website links are provided to assist you in locating Local Coverage Determinations (LCDs). Please review the “Draft Policy/LCDs” area for draft LCDs and to provide comments; the “Draft Open Sessions” area to find when and where the Open Sessions are scheduled, and the “Current Policy/LCDs” area for active LCDs.”

- [Part A PA and MD/DC Fiscal Intermediary LCD's](#)
- [PA Part B Carrier LCD's](#)

Important Telephone Numbers

Provider Contact Center

1-800-560-6170 (PA Providers)

1-866-488-0545 (MD/DC Providers)

Medicare EDI Services

1-866-488-0546, option 2

CERT Coordinator

QuestCert@highmark.com

FISS Password Resets

1-800-560-6170 (PA Providers)

1-866-488-0545 (MD/DC Providers)

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