MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – A HIPAA 5010 Special Edition MLN Matters provider education article is now available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf* on the CMS website. This Special Edition article alerts providers regarding the implementation of HIPAA 5010 which presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries and outlines how providers need to plan for implementation of these changes.

MLN Matters® Number: MM6512 Revised

Related Change Request (CR) #: 6512

Related CR Release Date: September 18, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1818CP

Implementation Date: January 4, 2010

Revised Processing of Osteoporosis Drugs under the Home Health Benefit

Note: This article was revised on September 21, 2009, to reflect revisions made to CR 6512, which was re-issued on September 18. The CR Release Date, Transmittal Number (see above), and the Web address for accessing CR 6512 were revised. All other information is the same.

Provider Types Affected

Home Health Agencies (HHA) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHI), Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC)) for injectable osteoporosis drugs provided to Medicare beneficiaries are affected.

Provider Action Needed

HHAs are reminded that the current criteria for coverage of injectable osteoporosis drugs must be met when submitting claims for these drugs. There is no change in these criteria. However, this article explains that the date of service on claims submitted for covered osteoporosis drugs must fall within the start and end dates of an existing home health prospective payment system (PPS) episode. Please inform your billing staffs of this requirement.

Background

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.

Medicare covers injectable osteoporosis drugs if certain criteria are met. These criteria include:

- Eligibility for coverage of home health services;
- Physician certification that the individual sustained a bone fracture related to post-menopausal osteoporosis; and
- Physician certification that the female patient is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Currently, the second and third criteria are enforced to the extent possible through Medicare systems by edits that require that the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present. However, the first criterion that the beneficiary must be covered under the home health benefit is only partially enforced. If an osteoporosis claim is received and a home health episode of care is on file, Medicare requires that the provider number of the HHA submitting the osteoporosis claim must be the same as the provider number on the episode record. CR 6512 revises the Medicare systems to fully enforce this criterion by requiring that the date of service for an injectable osteoporosis drug on a home health claim falls within the start and end dates of an existing home health episode if the claim contains:

- Type of bill 34x;
- Healthcare Common Procedure Coding Systems (HCPCS) codes J0630, J3110, or J3490; and
- Covered charges corresponding to these HCPCS codes.

Claims not meeting the criteria for coverage will be rejected with the following messages: MSN message 6.5, “Medicare cannot pay for this injection because one or more requirements for coverage were not met;" and claim adjustment reason code 177, “Patient has not met the required eligibility requirements.”

Additional Information

If you have questions, please contact your Medicare RHHI, FI, and/or MAC at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the Centers for Medicare & Medicaid Services (CMS) website. The official instruction, CR 6512, issued to your Medicare RHHI, FI, and/or MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1818CP.pdf* on the CMS website.

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