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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

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Administrative Information

Are you disputing an overpayment?	2
Notice of New Interest Rate for Medicare Overpayments & Underpayments: 4th Notification for FY 2009	2
Claim Status Category Code and Claim Status Code Update	3
Medicare Billing Privileges: Revisions to Certain Items in CMS Change Request 6310	4-5
Expiration of Medicare Processing of Certain Indian Health Service (IHS) Part B Claims	6
Medicare Contractor Annual Update of ICD-9-CM	7

DMEPOS

Prepare for the Medicare DMEPOS Competitive Bidding Program	8-10
---	------

Drugs & Biologicals

Hemophilia Clotting Factors: Submitting the Number of Units.....	11-12
--	-------

Education

Provider Education Listserv.....	13
----------------------------------	----

Medicine

Coding and Reporting Principles for the Physician Quality Reporting Initiative & Electronic Prescribing (E-Prescribing) Incentive Programs	14-23
Sleep Testing for Obstructive Sleep Apnea (OSA)	24-25
Expansion of the Current Scope of Editing for Ordering/Referring Providers	26-27
Billing Routine Costs of Clinical Trials	28-29

Specialty: Nephrology

ESRD: List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD) Related	30
---	----

Specialty: Laboratory

Laboratory National Coverage Determination (NCD) Edit Software Changes: October 2009.....	31-33
---	-------

Specialty: Surgery

Wrong Surgical or Other Invasive Procedure Performed on a Patient.....	34-38
--	-------

Continued on next page



You Are Responsible. . .

The *Medicare Advisory* contains coverage, billing, and other information for providers in Ohio and West Virginia. This information is not intended to constitute legal advice. It is our official notice to the providers we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA Web site. It is the responsibility of each provider to obtain this information and to follow the guidelines. The *Medicare Advisory* includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time.

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 Web site at: <http://www.PalmettoGBA.com>.

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Etcetera

Medical Director’s Desk.....	39
Local Coverage Determination Updates.....	40
Redetermination/Reopening Request For Medicare Part B Claims For Ohio & West Virginia.....	41
Reconsideration Request Form - QIC North (Ohio).....	42
Reconsideration Request Form - QIC South (West Virginia).....	43

Are You Disputing an Overpayment?

When requesting a redetermination of an overpayment, the identification of the Appeal as an “Appeal of an Overpayment” is critical in stopping additional funds from being offset in a timely manner. The following steps will help to ensure that your request is received in the appropriate area quicker and that your offset is stopped in a timely manner while your Appeal is being processed.

In order for Palmetto GBA to stop offsetting your claims, we must be able to identify the redetermination request as a dispute of the overpayment. Check the “Appeal of an Overpayment” box on the redetermination request form and/or attach a copy of the overpayment letter to your request.

Please go to the following link to select the Redetermination/Reopening Request Form, which is located under Self Service Tools and Top Links:

- Ohio: <http://www.PalmettoGBA.com/boh>
- West Virginia: <http://www.PalmettoGBA.com/bwv>

Notice of New Interest Rate for Medicare Overpayments & Underpayments: 4th Notification for FY 2009

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (3 percent for calendar year 2009) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to **11.25 percent** effective **July 17, 2009**.

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Claim Status Category Code and Claim Status Code Update

Provider Types Affected

All physicians, providers and suppliers submitting claims to Palmetto GBA for Medicare beneficiaries are affected.

Provider Action Needed

This article, based on CR 6525, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on March 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the January 2009 committee meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on March 1, 2009. Medicare will implement those changes on July 6, 2009, as a result of CR 6525.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1756CP.pdf>.

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

Medicare Billing Privileges: Revisions to Certain Items in CMS Change Request 6310

Provider Types Affected

Physicians, suppliers and other providers who bill Palmetto GBA.

Provider Action Needed

This article, based on CR 6491, clarifies manual instructions found in the Centers for Medicare & Medicaid Services' (CMS) CR 6310.

Background

The Medicare Program Integrity Manual, chapter 10, section 13, available at <http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf>, contains information about deactivations, reactivations and revocations of Medicare billing privileges and their respective effective dates. Portions of this manual chapter are being revised by CR 6491 and those changes are summarized below:

- Medicare contractors will ensure that a supplier that has had its Medicare billing privileges reactivated does not become subject to a second deactivation for non-billing within 30 days of the reactivation
- For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals, Medicare contractors will establish the reactivation effective date as the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location, unless the supplier has at least one other enrolled practice location (under the same TIN) for which it is actively billing Medicare, the contractor shall establish and enter the reactivation effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later.
- If the individual (physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals) or organizational supplier reports a change in practice location more than 30 days after the effective date of the change, the supplier's billing privileges are not revoked on this basis. However, if the Medicare contractor independently determines, through an on-site inspection under 42 CFR Section 424.535(a)(5)(ii) or via another verification process, that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the supplier's billing privileges may be revoked.

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Additional Information

The official instruction, CR 6491, issued to Palmetto GBA regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R295PI.pdf>. Attached to the CR are the revised portions of the Program Integrity Manual.

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

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Expiration of Medicare Processing of Certain Indian Health Service (IHS) Part B Claims

Provider Types Affected

Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based) facilities submitting claims to Palmetto GBA.

Provider Action Needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected Indian Health Service (IHS) physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for 'other' Part B services, including Durable Medical Equipment (DME), prosthetics, orthotics, therapeutic shoes, clinical laboratory services, surgical dressing, splints and casts, drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier) and ambulance services. As a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, coverage of these 'other' Part B items and services started January 1, 2005, for a five-year period which ends January 1, 2010. This article alerts affected providers that the five-year period expires as of January 1, 2010.

Background

The Social Security Act (Section 1880; see http://www.ssa.gov/OP_Home/ssact/title18/1880.htm) provides for payment to Indian Health Service (IHS) facilities for services paid under the physician fee schedule.

Additionally, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 630) expanded the scope of items and services for which payment could be made to IHS facilities to include all 'other' Part B covered items and services for a 5 year period beginning January 1, 2005, and ending January 1, 2010. See Change Request (CR) 3288 at <http://www.cms.hhs.gov/transmittals/downloads/R241CP.PDF>. An MLN Matters® article related to that transmittal is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3288.pdf>.

This special edition article is being provided by CMS to notify affected IHS physicians, IHS providers, and IHS suppliers that beginning January 1, 2010; IHS facilities can no longer bill Medicare for the following Part B services:

- Durable medical equipment (DME)
- Prosthetics and orthotics
- Surgical dressings, Splints and Casts
- Therapeutic shoes
- Drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier)
- Clinical laboratory services and
- Ambulance services

Additional Information

If you have any questions, please contact our Provider Contact Center at (866) 332-7025.

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Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Provider Types Affected

Physicians, suppliers and providers billing Palmetto GBA.

Provider Action Needed

This article is based on Change Request (CR) 6520 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes at

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6520 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

The official instruction (CR 6520) issued to Palmetto GBA is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1770CP.pdf>.

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

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Take Action Now to Prepare for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Provider Types Affected

Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that wish to participate in the upcoming Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program.

Provider Action Needed

In order to participate in the 2009 Round 1 Rebid of the DMEPOS Competitive Bidding Program, suppliers will be required to register in the Centers for Medicare & Medicaid Services (CMS) security system known as the Individuals Authorized Access to the CMS Computer Services (IACS). This includes suppliers that bid in the first round of competition in 2007 and are interested in competing in the Round 1 Rebid. CMS urges suppliers' planning to bid in the 2009 bidding cycle to be sure that they have provided the National Supplier Clearinghouse (NSC) an updated CMS-855S (Medicare Enrollment Application), with any changes made concerning their Authorized Official(s) information and correspondence mailing address which have occurred since their last CMS-855S submission. The accuracy of this data is critical for successful bidder registration.

Background

In this year's bid cycle, suppliers who wish to bid will need to first register in IACS once the registration window opens. There will be three user roles available, which are described as follows:

- Authorized Official (AO) - Each supplier's organization will be allowed one AO. The AO role can approve all other users associated with their organization who are requesting access to the bidding system. The AO will be able to input bid data, approve Form A and certify Form B in the bidding system.
- Backup Authorized Official (BAO) - Each supplier organization is encouraged to designate one or more BAOs. This applies when the organization has additional personnel who qualify as an AO. In this role, the BAO can approve the supplier's End User registration for access to the bidding system. Like the AO, the BAO can also input bid data, approve Form A and certify Form B in the bidding system.
- End User - Each supplier organization will be allowed one or more End User(s). The End User can input bid data, but cannot approve Form A or certify Form B.

Save Time and Potential Delay by Verifying CMS-855S Information Prior to Registering to Bid

Only those AOs listed on the CMS-855S as an AO can register in IACS to approve and certify as described above for the AO and BAO user roles. As part of the CMS-855S, a supplier designates one or more AO(s). The AO means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations and program instructions of the Medicare program.

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Take Action Now

Be sure the most recent CMS-855S submission is current and accurate. In particular, this concerns:

- The AO's personal identifying information, including the AO's legal name, date of birth, and Social Security number (SSN) as on file with the Social Security Administration (SSA). Make sure the AO's legal name, date of birth and SSN in sections 6 and 15 of the CMS-855S reflects that which is on file with SSA. Reviewing a Social Security card or most recent Social Security Statement is a fast and easy way to verify information on file with SSA. If the information on file at SSA is not correct, then you should immediately contact SSA and have the correction made.
- The supplier's correspondence mailing address as reflected in section 2A2 of the CMS-855S.

If any of these data elements have changed since your last submission of the CMS-855S to the NSC or if the AO's personal identifying information on the CMS-855S does not exactly reflect that which is on file with the SSA, and then you should PROMPTLY complete a change of information on the CMS-855S. Remember, any change of name reported to SSA should also be reported to the NSC on the CMS-855S.

CMS urges suppliers to do it now. The NSC processing time to complete a change of information on the CMS-855S is approximately 45 days, and all submissions are processed in the order in which they are received.

Overview of IACS Registration Process

For an AO, the verification of his/her legal name, date of birth and SSN must be validated against SSA's records and AO data maintained by the NSC. The NSC received this AO data when the supplier completed its most recent CMS-855S. The AO's legal name, date of birth, and SSN are listed in sections 6 and 15 of the CMS-855S. If the AO legal name, date of birth and SSN data input into IACS during registration does not match SSA's records and NSC AO data, the registration will be rejected.

Following successful registration, as an added measure of security, the AO's User ID and password are then mailed in two separate correspondences to the mailing address listed in section 2A2 of the CMS-855S.

The BAO goes through the same verification process described above for the AO and the AO for the organization must approve a BAO's request for access before a User ID and password will be e-mailed to the BAO. The BAO must be listed on the CMS-855S as an AO, sections 6 and 15. It is critical that the BAO's legal name, date of birth and SSN data input into IACS during registration matches SSA's records and NSC AO data, otherwise the BAO registration will be rejected.

End Users do not need to be listed on the CMS-855S as an AO. However, their legal name, date of birth and SSN will be verified against SSA's records, and the AO or BAO for the organization will need to approve an End User's request for access to the bidding system.

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Do I need a BAO role?

The establishment of a BAO is encouraged, if the organization has someone that can occupy the BAO role, to avoid any disruption in the bidding process. The AO's role is instrumental to bidding, as the AO's role must be active to avoid all other users of the organization from losing access to the bidding system. If the AO leaves the organization, the BAO role can be changed to an AO role by the Competitive Bidding Implementation Contractor (CBIC) Help Desk.

Additional Information

This article provides you with an overview of the registration process. More detailed instructions will be published in future MLN Matters® articles, listserv messages, and other announcements.

For more information on the DMEPOS competitive bidding program, visit <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>.

Hemophilia Clotting Factors: Submitting the Number of Units

Submitting the correct Quantity Billed (QB) for hemophilia clotting factors is essential to receiving correct reimbursement. To calculate the correct QB, divide the number of International Units (IUs) administered by 100, and round to the nearest whole number.

Effective July 1, 2009, HCPCS codes for Hemophilia clotting Factors are J7186, J7187, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7197, J7198, J7199 and Q2023.

Providers are reminded to report the number of IUs given by:

- First, divide the number given by 100
- Second, round to the nearest whole number to determine the billing unit
 - Fractions from .50 to .99 = 1 additional billing unit
 - Fraction from .01 to .49 = NO additional billing unit
- Report the result in the units field of the claim form

Example 1:

A patient received 1232 IU of Factor VIII.

Divide 1232 by 100 ($1232/100 = 12.32$). Round to the nearest whole number (12). Report the result (0120) in the units field (item 24G) of the claim form.

Example 2:

A patient received 25778 IU of anti-inhibitor coagulant complex.

Divide 25778 by 100 ($25778/100 = 257.78$). Round to the nearest whole number (258). Report the result (2580) in the units field (item 24G) of the claim form.

Example 3:

A patient received 5798 IU of Factor IX.

Divide 5798 by 100 ($5798/100 = 57.98$). Round to the nearest whole number (58). Report the result (0580) in the units field (item 24G) of the claim form.

Exception: Not otherwise classified HCPCS code (NOC) J7199.

This code requires the drug name and total IUs submitted (i.e. dosage) in Loop 2300, or 2400, NTE, 02 for electronic claims. For paper claims, submit this information in Item 19 of the CMS-1500 claim form.

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Important:

If the calculated QB exceeds the total units indicated below for the specific HCPCS code, the reimbursement amount may be calculated incorrectly. In order to ensure that your reimbursement is correct in these instances, split the service onto two detail lines:

- HCPCS codes J7186, J7187, J7190, J7193, J7194: submit up to 9990 on a single detail line
- HCPCS code J7189: submit up to 7500 on a single detail line
- HCPCS codes J7192 and J7195: submit up to 9000 on a single detail line
- HCPCS code J7197: submit up to 4000 on a single detail line
- HCPCS code J7198: submit up to 6500 on a single detail line
- HCPCS code Q2023: submit up to 8500 on a single detail line
- For charges that exceed \$99,999.99 on a single claim refer to the article titled 'Limits on Billed Amounts: Instructions for Submitting Claims.'

Currently, these large dosages are being submitted by pharmacies.

Provider Education Listserv

The Palmetto GBA list serv is a wonderful communication tool that offers its members the opportunity to keep informed of:

- Medicare updates
- *Medicare Advisory* articles
- Fee Schedule changes
- LCD/NCD changes
- And so much more!

What is needed to receive updates?

- Internet access
- Completion of the form below
- Palmetto GBA will enter the information you provide into the online registration
- This information will not be shared with any mailing list

Note: Once the registration information is entered, you will receive a confirmation/welcome message informing you that you've been successfully added to our List Serv. You must acknowledge this confirmation within 3 days of your registration.

FAX the completed form to (614) 473-6812

User Name (email address)	
Print First and Last Name	
Password	S3cret*1
Your E-mail Address	

Topics (mark those you're interested in staying informed about)

Allergy/Immunology	Gastroenterology	Physician
Ambulance	General - Part B	Podiatry
Ambulatory Surgical Center	Gynecology	Primary Care
Anesthesia	Hematology/Oncology	Psychology/Psychiatry
Cardiovascular	Independent Diagnostic Testing Facilities	Pulmonary/Critical Care
Chiropractic	Nephrology	Radiology
Community Mental Health Center	Neurology	Religious Non-Medical Health Care
Dermatology	Non-Physician Practitioners	Surgery
Diagnostic Tests	Ophthalmology/Optometry	
Drugs/Biologicals	Organ Procurement	
Electronic Data Interchange (EDI)	Pathology & Laboratory	
Federally Qualified Health Center	Physical/Occupational	

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Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs

Provider Types Affected

Physicians and practitioners (referred to as eligible professionals (EPs)) who wish to participate in the Medicare Physician Quality Reporting Initiative (PQRI) and/or the E-Prescribing Incentive programs in 2009.

What You Need to Know

CR 6514, from which this article is taken, provides a high-level overview of the coding and reporting principles for the claims-based reporting of quality measures data for the 2009 PQRI, and for the claims-based reporting of the e-prescribing measure for the 2009 E-Prescribing Incentive Program. Because the information in CR 6514 is quite detailed and important for these two programs, this article will mirror virtually all of that detail.

Background

The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007. The Centers for Medicare & Medicaid Services (CMS) named this program the Physician Quality Reporting Initiative (PQRI).

For the 2009 PQRI, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) required the Secretary of Health and Human Services (HHS) to select measures for 2009 through rulemaking, and to establish alternative reporting criteria and alternative reporting periods for reporting on a group of measures, or measures groups, and for registry-based reporting. In addition, the Medicare Improvements for Patients and Providers Act (MIPPA), which was enacted on July 15, 2008, includes many provisions that impact the 2009 PQRI. Thus, for 2009, PQRI submission of quality data may be performed via claims or via a qualified registry; and multiple reporting options are available for each method of submission, including the option of reporting on individual quality measures or on measures groups.

Section 132 of the MIPPA also authorizes a new and separate incentive program for EPs who are successful electronic prescribers (e-prescribers) as defined by MIPPA. This new incentive is separate from, and in addition to, the PQRI. To be considered a successful e-prescriber for 2009, an EP must report an e-prescribing measure in at least 50 percent of reportable cases. For 2009, the e-prescribing measure may be reported via claims only.

To be considered a successful e-prescriber for 2009, an EP must report an e-prescribing measure on at least 50 percent of reportable cases and at least 10 percent of an EP's total allowed Medicare Part B charges must

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come from the services delineated in the measure's denominator. For 2009, the e-prescribing measure may be reported via claims only.

CR 6514, from which this article is taken, provides a high-level overview of the coding and reporting principles for the claims-based reporting of quality measures data for the 2009 PQRI, and for the claims-based reporting of the e-prescribing measure for the 2009 E-Prescribing Incentive Program.

Coding and Reporting Principles for the Claims-based Reporting of PQRI Measures

To implement 2009 PQRI claims-based reporting of measures or measures groups, eligible professionals (EPs), using your individual national provider identifier (NPI) and submitting billable services on Part B claims for allowable Medicare Physician Fee Schedule (MPFS) charges, may report the quality action for selected PQRI quality measure(s) or measures groups, which are comprised of four or more PQRI quality measures. In general, the PQRI quality measures consist of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population: 1) who receive a particular process of care or achieve a particular outcome, or 2) for whom care was delivered using a particular structural element. It is important that you review and understand each measure specification, which provides definitions and specific instructions for reporting a measure.

Note: 1) You should review the following documents if you choose to report individual PQRI quality measures:

- '2009 PQRI Measure Specifications Manual for Claims and Registry'
- '2009 PQRI Implementation Guide,' which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in Centers for Medicare & Medicaid Services (CMS) 1500 format

2) You should review the following documents if you choose to report PQRI measures groups:

- '2009 PQRI Measures Groups Specifications Manual'. Note that the specifications for a measures group are different from those for individual measures because measures groups require a common denominator. Be sure you use the correct specifications.
- 'Getting Started with 2009 PQRI Reporting of Measures Groups' – this is the implementation guide for reporting measures groups
- '2009 PQRI Tip Sheet: PQRI Made Simple – Reporting the Preventive Care Measures Group' – this tip sheet provides a useful worksheet to keep track of each patient reported when using the 30-consecutive patient sample method for a measures group

You can find the first four documents on the Measures/Codes section of the CMS PQRI Web site at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, and the fifth on the Educational Resources section of the CMS PQRI Web site at http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage.

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PQRI measures consist of two major components: 1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator); and 2) A numerator that describes the quality action required by the measure for reporting and performance. Each component is defined by specific codes described in each measure specification along with reporting instructions and use of modifiers.

Current Procedural Terminology (CPT) Category I Modifiers

The PQRI measure specifications include specific instructions regarding inclusion of CPT Category I modifiers. Unless otherwise specified, CPT Category I codes may be reported with or without CPT modifiers. You should refer to each individual measure specification for detailed instructions to identify CPT Category I modifiers that qualify or do not qualify a claim for denominator inclusion.

Please note that PQRI-eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with CPT modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for applicable PQRI measure(s). Both surgeons participating in PQRI will be fully accountable for the quality action(s) described in the PQRI measure(s).

However, surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so their performance rates will not be negatively impacted for PQRI. PQRI analyses will exclude otherwise PQRI-eligible CPT Category I codes, when submitted with assistant surgeon CPT modifiers 80, 81, or 82. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRI measures.

Quality-Data Codes (QDCs)

QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the quality action required by a measure's numerator. Quality actions can apply to more than one condition, and therefore can also apply to more than one measure. Where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish quality actions across measures. Some measures require more than one quality action and therefore have more than one CPT Category II code, G-code, or a combination associated with them. You should review numerator reporting instructions carefully.

CPT Category II Codes

CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the quality action(s) described in a measure's numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter 'F.' CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRI.

Use of CPT II Modifiers

CPT II modifiers are unique to CPT II codes and may be used to report PQRI measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code are mutually

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exclusive and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of an exclusion modifier may be appropriate. Note that in a pay-for-reporting model, accurate reporting on all selected applicable measures counts the same, whether reporting that the quality action was performed or not.

CPT II code modifiers fall into two categories, exclusion modifiers and the 8P reporting CPT modifier:

1) Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not allow performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:

- 1P exclusion CPT modifier due to medical reasons

Examples include: not indicated (absence of organ/limb, already received/performed, other); contraindicated (patient allergic history, potential adverse drug interaction, other); other medical reasons.

- 2P exclusion CPT modifier due to patient reasons

Examples include: patient declined; economic, social, or religious reasons; other patient reasons.

- 3P exclusion CPT modifier due to system reasons

Examples include: resources to perform the services not available (e.g., equipment, supplies); insurance coverage or payer-related limitations; other reasons attributable to health care delivery system.

2) The 8P reporting CPT modifier is available for use only with CPT II codes to facilitate reporting a denominator eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting CPT modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.

- 8P reporting CPT modifier - action not performed, reason not otherwise specified

The 8P reporting CPT modifier facilitates reporting an eligible case on a given measure when the quality action does not apply to a specific encounter. EPs can use the 8P CPT modifier to receive credit for satisfactory reporting but will not receive credit for performance.

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For example, a clinician who has selected and submitted QDCs during the reporting period for 2009 PQRI Measure #6, Oral Antiplatelet Therapy, sees a patient during an encounter and the claim for services for that encounter contains ICD-9-CM and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P CPT modifier serves to include the patient in the numerator when reporting rates are calculated for PQRI.

Claims-Based Reporting Principles for PQRI

The following principles apply to the reporting of QDCs for PQRI measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
 - On the same claim as the denominator billing code(s)
 - For the same beneficiary
 - For the same date of service (DOS)
 - By the same EP (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator
- All diagnoses reported on the base claim, regardless of the order listed, will be included in PQRI analysis, as some PQRI measures require reporting more than one diagnosis on a claim. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.
- Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically.
- If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny, to one of the line items on that second claim for a total charge of one penny. PQRI analysis will subsequently join both claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim. You should work with your billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.
- QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed
 - The submitted charge field cannot be blank
 - The line item charge should be \$0.00
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount
 - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00.)
 - Whether a \$0.00 charge or a nominal amount is submitted to the carrier/contractor, the PQRI QDC line is denied and tracked
- QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. EPs will receive a Remittance Advice (RA) associated with the claim which will contain the PQRI QDC line-item and will include a standard remark code (N365) and a message that

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confirms that the QDC(s) passed into the National Claims History (NCH) file. N365 reads: 'This procedure code is not payable. It is for reporting/information purposes only.' The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.

- Multiple EPs' QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, you should follow their normal billing practice of placing the NPI of the individual EP who rendered the service on each line item on the claim including the QDC line(s).
- Some measures require the submission of more than one QDC in order to properly report the measure. Report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.
- Solo practitioners should follow your normal billing practice of placing your individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent)
- EPs may submit multiple codes for more than one measure on a single claim
 - Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim
 - If a denied claim is subsequently corrected through the appeals process to the Palmetto GBA, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications
 - Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs

You may submit QDCs to Palmetto GBA either through electronic or paper based submission.

When using electronic submission, which is accomplished using the ASC X 12N Health Care Claim Transaction (Version 4010A1), you should submit CPT Category II and/or temporary G-codes in the SV101-2 'Product/Service ID' Data Element on the SV1 'Professional Service' Segment of the 2400 'Service Line' Loop.

You must also identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 'Professional Service' Segment. Further, you should submit diagnosis codes at the claim level, Loop 2300, in data element HI01, and if there are multiple diagnosis codes, in HI02 through HI08 as needed with a single reference number in the diagnosis pointer. In general for group billing, you should report the NPI for the rendering provider in Loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data element NM109 (with NM108=XX).

For paper-based submissions, use the CMS-1500 claim form (version 08-05). Enter the relevant ICD-9-CM diagnosis codes in Field 21 and enter Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers in Field 24D with a single reference number in the diagnosis pointer

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Field 24E that corresponds with the diagnosis number in Field 21.

For group billing, you should enter the National Provider Identifier (NPI) of the rendering in Field 24J, and the Tax Identification Number (TIN) of the employer is entered in Field 25.

Group and Solo NPI Submission

When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo practitioners must include your individual NPI on the claim line as is the normal billing process for submitting Medicare claims. For PQRI, the QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

Timeliness of Quality Data Submission

You should be aware that claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2010, to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Analysis of PQRI Data: Reporting Frequency and Performance Timeframes

Instructions for some measures limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Some measures, due to their complexity, are reportable as registry only or measures group only.

Each measure specification includes a reporting frequency for each denominator-eligible patient seen during the reporting period. The reporting frequency described in the instructions applies to each individual EP participating in PQRI. PQRI uses the reporting frequency to analyze each measure for determination of satisfactory reporting:

- Patient-Process: Report a minimum of once per reporting period per individual EP (NPI)
- Patient-Intermediate: Report a minimum of once per reporting period per individual EP (NPI)
- Patient-Periodic: Report once per timeframe specified in the measure for each individual EP (NPI) during the reporting period
- Episode: Report once for each occurrence of a particular illness/condition by each individual EP (NPI) during the reporting period
- Procedure: Report each time a procedure is performed by the individual EP (NPI) during the reporting period
- Visit: Report each time the patient is seen by the individual EP (NPI) during the reporting period

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the quality action described in the numerator may be accomplished.

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Coding and Reporting Principles for Claims-based Reporting of the E-Prescribing Measure

Similar to the PQRI, the e-prescribing measure consists of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population for whom care was delivered using a particular structural element. Also, similar to PQRI, claims-based reporting of the e-prescribing measure requires EPs, using their individual national provider identifier (NPI) and submitting billable services on Part B claims for allowable PFS charges, to report the quality action for the e-prescribing measure. You should review and understand the e-prescribing measure specification, which provides definitions and specific instructions for reporting the measure.

Note: you should review the following documents if you choose to participate in the E-Prescribing Incentive Program:

- ‘E-Prescribing Measure Specifications’
- ‘Claims-based Reporting Principles for E-Prescribing’ – this provides guidance about how to report the e-prescribing measure on claims
- ‘Sample E-Prescribing Claim’ – this provides a detailed sample of an individual NPI reporting the e-prescribing measure on a CMS-1500 claim

These documents are all available on the E-Prescribing Measure section page of the E-Prescribing Incentive Web site at <http://www.cms.hhs.gov/ERXIncentive>. In addition, Educational resources to assist you in successfully participating in the E-Prescribing Incentive Program are also available on the Educational Resources section page of the E-Prescribing Incentive Web site at http://www.cms.hhs.gov/ERxIncentive/09_Educational_Resources.asp#TopOfPage.

The following principles apply for claims-based reporting of the e-prescribing measure:

1. You should report one of the three e-prescribing codes listed below as the claim numerator:
 - HCPCS code G8443 - ‘All prescriptions created during the encounter were generated using a qualified e-prescribing system.’
 - HCPCS code G8445 - ‘No prescriptions were generated during the encounter.’
 - HCPCS code G8446 - ‘Provider does have access to a qualified e-prescribing system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances.’
2. You must report the e-prescribing code (which supplies the numerator):
 - On the same claim as the denominator billing code
 - For the same beneficiary
 - For the same date of service (DOS)
 - By the same EP (individual NPI) who performed the covered service

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3. You must submit the e-prescribing code with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
 - The submitted charge field cannot be blank
 - The line item charge should be \$0.00
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount
 - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00.)
 - Whether a \$0.00 charge or a nominal amount is submitted to the carrier/MAC, the e-prescribing code line is denied and tracked
 - E-prescribing line items will be denied for payment, but are passed through the claims processing system to Medicare's National Claims History database (NCH), used for e-prescribing claims analysis. EPs will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: 'This procedure code is not payable. It is for reporting/information purposes only.' The N365 remark code does NOT indicate whether the e-prescribing code is accurate for that claim or for the measure the EP is attempting to report. N365 only indicates that the e-prescribing code passed into NCH.
4. When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items. Solo practitioners should follow your normal billing practice of placing your individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).
5. Claims may NOT be resubmitted for the sole purpose of adding or correcting an e-prescribing code.

Submission through Carriers/MACs

You may submit E-prescribing codes to carriers/MACs either through electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or paper-based submission using the CMS-1500 claim form.

When using electronic submission you should submit the E-prescribing codes in the SV101-2 'Product/Service ID' Data Element on the SV1 'Professional Service' Segment of the 2400 'Service Line' Loop. You will need to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 'Professional Service' Segment.

You should submit diagnosis codes at the claim level, Loop 2300, in data element HI01, and if there are multiple diagnosis codes, in HI02 through HI08 as needed with a single reference number in the diagnosis pointer.

In general for group billing, report the NPI for the rendering provider in Loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data elements NM108 and NM109.

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For Paper-based submissions, use the CMS-1500 claim form (version 08-05) and enter relevant ICD-9-CM diagnosis codes in Field 21. Enter service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers in Field 24D with a single reference number in the diagnosis pointer Field 24E that corresponds with the diagnosis number in Field 21.

For group billing, the NPI of the rendering/performing provider is entered in Field 24J and the TIN of the employer is entered in Field 25.

Timeliness of Quality Data Submission

As mentioned above, claims processed by the Carrier/MAC must reach the Medicare NCH file by February 28, 2010, to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Additional Information

- The official instruction, CR 6514, issued to your carrier/MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R513OTN.pdf>
- You can find additional information about PQRI at <http://www.cms.hhs.gov/PQRI>
- Additional information on the E-Prescribing Incentive Program is available at <http://www.cms.hhs.gov/ERXIncentive>

If you have any questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

Sleep Testing for Obstructive Sleep Apnea (OSA)

Provider Types Affected

Physicians and providers submitting claims to Palmetto GBA for services provided for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6534 which announces that Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of OSA as contained in section 240.4.1 of the National Coverage Determination (NCD) Manual. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has addressed the coverage of continuous positive airway pressure (CPAP) in three separate decisions in October 2001, April 2005, and March 2008. In each of those decisions, CMS limited coverage of CPAP in patients with OSA to those patients whose diagnosis was based on specific testing modalities. Initially, it limited coverage to OSA diagnosed with polysomnography (PSG). In the latest decision, it expanded coverage to OSA diagnosed with several types of home sleep tests. However, CMS has not, at a national level, specifically addressed coverage of the tests themselves. In other words, CPAP is nationally covered for beneficiaries with OSA if diagnosed with these specific tests; yet, coverage of the specific tests has previously been left to local contractor discretion.

After careful consideration, Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of OSA as contained in section 240.4.1 of the NCD Manual.

Effective for claims with dates of service on and after March 3, 2009, Medicare will allow for coverage of the following:

1. Type I PSG when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility
2. Type II or Type III sleep testing device when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility
3. Type IV sleep testing device measuring three or more channels, one of which is airflow, when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility
4. Sleep testing device measuring three or more channels that include actigraphy, oximetry and peripheral arterial tone when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility

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Nationally Non-Covered Indications:

Effective for claims with dates of services on and after March 3, 2009, other diagnostic sleep tests for the diagnosis of OSA, other than those noted above for prescribing CPAP, are not sufficient for the coverage of CPAP and are not covered.

NOTE: All current claims processing and associated coding remain unchanged. Consult CR 6048, dated October 15, 2008, for detailed claims processing information. The MLN Matters® Article related to CR 6048 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6048.pdf>.

Additional Information

Note that Medicare contractors will not search their files to adjust claims processed prior to the implementation date of CR 6534. However, they will adjust such claims that you bring to their attention.

The official instruction (CR 6534) issued to Palmetto GBA may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R103NCD.pdf>.

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

Expansion of the Current Scope of Editing for Ordering/Referring Providers

Note: This article was revised on June 29, 2009, to reflect revisions that the Centers for Medicare & Medicaid Services (CMS) made to CR 6417 on June 26. In the revised CR 6417, CMS clarified the way claims will be processed in phases 1 and 2 and the article was revised accordingly. The article also reflects the remittance advice message that will be supplied on certain claims during phase 1. The CR release date, transmittal number and the CR Web address were also changed. All other information is the same.

Provider Types Affected

Physicians and non-physician practitioners who order and/or refer services that are billed to Palmetto GBA for Medicare beneficiaries.

What You Need to Know

CR 6417, on which this article is based, announces that in order to comply with Social Security Act requirements, the Centers for Medicare & Medicaid Services (CMS) is expanding claim editing to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer Medicare services. PLEASE NOTE: The changes being implemented with CR 6417 does not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer or any claims edits that may be in place with respect to those restrictions. Please refer to the Background Section, below, for more details.

Background

Only physicians and non-physician practitioners (who meet the definitions at section 1861(r) and 1842(b)(18)(C) of the Social Security Act (the Act)) are eligible to order or refer services for Medicare beneficiaries. In addition, Section 1833(q) of the Act requires that all physicians and non-physician practitioners who meet these definitions must be uniquely identified on all claims for services that they order or refer. More specifically, effective January 1, 1992, a physician or supplier who bills Medicare for a service or item that was the result of an order or referral must show the name and unique identifier of the ordering/referring provider on the claim. As of May 23, 2008, this unique identifier must be the National Provider Identifier (NPI).

CR 6417, from which this article is taken, announces that, effective October 5, 2009, CMS is expanding claim editing to meet these Social Security Act requirements to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer.

CR 6417 provides that only the following provider specialties can order or refer beneficiary services:

- Doctor of Medicine or Osteopathy
- Dental Medicine
- Dental Surgery
- Podiatric Medicine
- Optometrist

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- Chiropractic Medicine
- Physician Assistant
- Certified Clinical Nurse Specialist
- Nurse Practitioner
- Clinical Psychologist
- Certified Nurse Midwife or
- Clinical Social Worker

During Phase 1 implementation (beginning October 5, 2009), if the claim does not pass the edits described above, Medicare will continue to process the claim and will include a remark message (M68 – missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification) on the remittance advice.

In Phase 2, if the billed service requires an ordering/referring provider and none is present, the claim will not be paid.

If the ordering/referring provider is on the claim, Medicare will verify the ordering/referring provider's NPI and name reported on the claim against Medicare's provider enrollment records to ensure the ordering/referring provider is enrolled in Medicare and is a specialty eligible to order or refer.

Note: If multiple provider identification numbers (PINs) are associated to the NPI in MCS, Medicare contractors will use the first active PIN with an eligible specialty to order and refer.

Upon Phase 2 implementation and thereafter, the claim that does not pass the edits described above the claim will not be paid.

All physician and non-physician practitioners who order and refer items or services for Medicare beneficiaries should verify their Medicare enrollment. They may do so by going to http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage.

Additional Information

You can find the official instruction, CR 6417, issued to Palmetto GBA by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R510OTN.pdf>.

If you have any questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

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Billing Routine Costs of Clinical Trials

Note: This article was revised on June 29, 2009, to reflect a revised CR 6431, issued by the Centers for Medicare & Medicaid Services (CMS) on June 26, 2009. The transmittal number, CR release date (see above), and the Web address for accessing CR 6431 have changed. In addition, the implementation date was changed to September 28, 2009. All other information is the same.

Provider Types Affected

Physicians and non-physician practitioners submitting claims to Palmetto GBA for clinical trials

Provider Action Needed

This article is based on Change Request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.

Background

CR 6431 revises the Medicare Claims Processing Manual, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trails). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the QV or Q1 HCPCS modifier is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, Palmetto GBA will not consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed after September 28, 2009, with dates of service on or after January 1, 2008, claims submitted with either the HCPCS modifier QV or HCPCS modifier Q1 will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim
- Providers will see the following messages from their Medicare contractor with the returned claim:
 - Claims adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication; and
 - As least one Remark Code, which may be comprised of either:
 - The Remittance Advice Code (M76, Missing/incomplete/invalid diagnosis or condition) or
 - National Council for Prescription Drug Programs Reject Reason Code

Note: Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

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On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30
- Report a secondary diagnosis code of V70.7 and
- Identify all lines that contain an investigational item/service with a HCPCS modifier of:
 - QA/QR for dates of service before January 1, 2008, or
 - Q0 for dates of service on or after January 1, 2008
- Identify all lines that contain a routine service with a HCPCS modifier of:
 - QV for dates of service before January 1, 2008, or
 - Q1 for dates of service on or after January 1, 2008

Additional Information

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

The official instruction (CR 6431) issued to Palmetto GBA is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1761CP.pdf>.

ESRD: List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD) Related

Note: This article was revised on July 13, 2009, to reflect the revised CR 6515 issued by the Centers for Medicare & Medicaid Services on July 10, 2009. The effective and implementation dates of CR 6515 were revised to July 31, 2009. Also, the CR release date, transmittal number, and Web address for viewing CR 6515 were revised. All other information is the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Palmetto GBA for services provided to Medicare beneficiaries.

Provider Action Needed

This article is informational in nature and conveys that the purpose of Change Request (CR) 6515 is to place a listing of diagnostic tests that are considered ESRD-related as Exhibit 1 (new) at the end of Chapter 16 of the Medicare Claims Processing Manual.

Background

Change Request (CR) 6515 places the listing of diagnostic tests that are considered End Stage Renal Disease (ESRD)-Related as Exhibit 1 (formerly Attachment 1 in CR 2906) at the end of Chapter 16 of the Medicare Claims Processing Manual. This listing was inadvertently omitted from the manual during the implementation of CR 2906 (Transmittal 69, January 25, 2004; see <http://www.cms.hhs.gov/transmittals/downloads/R69CP.pdf>).

The purpose of CR 2906 was to address specific areas of concerns regarding Medicare system edits for Skilled Nursing Facilities (SNF) consolidated billing (CB) to permit payment for certain diagnostic services furnished to beneficiaries receiving treatment for ESRD at an Independent Provider-based dialysis facility. One of the areas of concern was that providers and suppliers needed a listing of diagnostic tests that are considered ESRD-Related that would require the CB HCPCS modifier. Consequently, a list defining specific diagnostic tests as ESRD-Related was included in CR 2906. This list applies only to SNF CB. According to CR 2906, any diagnostic services related to the beneficiary's ESRD treatment/care must be submitted using the CB HCPCS modifier, however, if these services are not on the list labeled as Attachment 1 in CR 2906 or the list being added to the Medicare Claims Processing Manual by CR 6515, your Medicare contractor may require supporting medical documentation.

To view the list being added to the end of Chapter 16 of the Medicare Claims Processing Manual, see CR6515, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1763CP.pdf>.

Additional Information

The official instruction, CR 6515, issued to Palmetto GBA regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1769CP.pdf>.

If you have any questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

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Laboratory National Coverage Determination (NCD) Edit Software Changes: October 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Palmetto GBA for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6548 which announces the changes that will be included in the October 2009 release of Medicare's edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in July 2009. Be sure billing staff are aware of the changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001.

Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2 (see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf>), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6548 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2009. These changes become effective for services furnished on or after October 1, 2009. The changes that are effective for dates of service on and after October 1, 2009 are as follows:

For the Urine Culture, Bacterial:

- Add ICD-9-CM codes 670.10, 670.12, 670.14, 670.20, 670.22, 670.24, 670.30, 670.32, 670.34, 670.80, 670.82, 670.84, and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the Urine Culture, Bacterial (190.12) NCD

For Blood Counts:

- Add ICD-9-CM codes V26.42, V26.82, V53.50-V53.51, V53.59, V61.07-V61.08, V61.23-V61.25, V61.42, V72.60-V72.63, and V72.69 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD
- Delete ICD-9-CM codes V53.5 and V72.6 from that list

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For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM codes 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PTT (190.16) NCD
- Delete ICD-9-CM code 453.8 from that list

For Prothrombin Time (PT):

- Add ICD-9-CM codes 209.70-209.75, 209.79, 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PT (190.17) NCD
- Delete ICD-9-CM code 453.8 from that list
- Replace the duplicate ICD-9-CM code 868.19 with 868.09 within that list

For Serum Iron Studies:

- Add ICD-9-CM codes 209.31-209.36, 209.70-209.75, 209.79, 239.81, 239.89, 285.3, 453.50-453.52 and 569.87 to the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD
- Delete ICD-9-CM code 239.8 from the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD

For Thyroid Testing:

- Add ICD-9-CM codes 279.41, 279.49, 784.42-784.44, 784.51, 784.59, 799.21-799.25, 799.29, and V10.91 to the list of ICD-9-CM codes that are covered by Medicare for the Thyroid Testing (190.22) NCD
- Delete ICD-9-CM codes 279.4, 784.5, and 799.2 from that list

For Lipids Testing:

- Add ICD-9-CM codes 438.13-438.14 to the list of ICD-9-CM codes that are covered by Medicare for the Lipids Testing (190.23) NCD

For Digoxin Therapeutic Drug Assay:

- Add ICD-9-CM codes 787.04, 799.21-799.25, 799.29 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD
- Delete ICD-9-CM code 799.2 from that list

For Alpha-fetoprotein:

- Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the Alpha-fetoprotein (190.25) NCD

For Carcinoembryonic Antigen:

- Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the Carcinoembryonic Antigen (190.26) NCD

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For Gamma Glutamyl Transferase:

- Add ICD-9-CM codes 209.70-209.75, 209.79, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 569.87, 969.00-969.05, 969.09, 969.70-969.73 and 969.79 to the list of ICD-9-CM codes that are covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD
- Delete ICD-9-CM codes 453.8, 969.0 and 969.7 from that list

For the Hepatitis Panel/Acute Hepatitis Panel:

- Add ICD-9-CM codes 787.04 and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD

For Fecal Occult Blood Test:

- Add ICD-9-CM codes 209.70-209.75, 209.79, 285.3, 569.87, 787.04, 789.7 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD
- Delete CPT® code G0394 from the list of CPT® codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD

For all 23 Lab NCDs:

- ICD-9-CM codes V20.31-V20.32, V60.81, V60.89, V80.01, and V80.09 will be denied for all 23 NCDs
- ICD-9-CM codes V60.8 and V80.0 will be deleted from the non-covered by Medicare lists for all 23 NCDs

Additional Information

The official instruction (CR 6548) issued to Palmetto GBA may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1766CP.pdf>.

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgery or Other Invasive Procedure Performed on the Wrong Body Part; and Surgical or Other Invasive Procedure Performed on the Wrong Patient

Note: This article was revised on July 6, 2009, to reflect a revised CR6405, which the Centers for Medicare & Medicaid Services issued on July 2, 2009. The CR release date and transmittal numbers (see above) were revised. The Web addresses for accessing the CR6405 transmittals are also changed in this article. All other information remains the same.

Provider Types Affected

Physicians, other practitioners, and providers billing Palmetto GBA for services provided to Medicare beneficiaries.

Provider Action Needed: Impact to You

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM) Chapter 1, sections 10 and 180 and Chapter 16, section 120. This is pursuant to the National Coverage Determinations (NCDs) made as part of CR 6405.

What You Need to Know

For inpatient claims, hospitals are required to bill two claims when the erroneous surgery related to the NCD is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

What You Need to Do

Make sure that your billing staffs are aware of these new billing and claim requirements.

Background

In 2002, the National Quality Forum (NQF) published Serious Reportable Events in Healthcare: A Consensus Report, which listed 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” (That report is available at <http://www.qualityforum.org/pdf/reports/sre.pdf>.) These events and subsequent revisions to the list became known as “never events.” This concept and need for the proposed reporting led to NQF’s “Consensus

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Standards Maintenance Committee on Serious Reportable Events,” which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally non-cover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM) Chapter 1, sections 10 and 180, and Chapter 16, section 120. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

NOTE: Related services do not include performance of the correct procedure.

Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient
- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine)

NOTE: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture

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changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient

Beneficiary Liability

Generally, a beneficiary liability notice such as an Advance Beneficiary Notice of Non-coverage (ABN) or a Hospital Issued Notice of Non-coverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the Medicare Claims Processing Manual, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the non-covered item/service. (The Medicare Claims Processing Manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the Medicare Claims Processing Manual, Chapter 30, Section 200

Thus, a provider cannot shift financial liability for the non-covered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the Medicare Claims Processing Manual.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the non-covered surgical error that would not be considered a related service to the non-covered surgical error (see Chapter 1, Sections 10 and 180, and Chapter 16, Section 120, of the Benefit Policy Manual).

Implementation: Inpatient Claims

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the NCD is reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and
- The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)

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The non-covered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in Form Locator (FL) 80 (Remarks), or the 837i (electronic) claim form, Loop 2300, one of the applicable 2-digit surgical error codes as follows:

- MX – for a wrong surgery on patient
- MY – for surgery on the wrong body part or
- MZ – for surgery on the wrong patient

The claim for the non-covered services will be denied using:

- Claim adjustment reason code (CARC) 50 - These are non-covered services because this is not deemed a ‘medical necessity’ by the payer
- Group Code CO - Contractual Obligation

Outpatient, Ambulatory Surgical Centers (ASCs), Other Appropriate Bill Types and Practitioner Claims

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- HCPCS modifier PA: Surgery Wrong Body Part
- HCPCS modifier PB: Surgery Wrong Patient
- HCPCS modifier PC: Wrong Surgery on Patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system control facility (SCF) rule shall be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- CARC 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer
- Group Code - CO – Contractual Obligation

Related Claims

Within 5 days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies

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such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6405) issued to Palmetto GBA. That instruction was issued in two transmittals. The first transmittal presents the National Coverage Determination related to this issue and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf>. The other transmittal presents the Medicare Claims Processing Manual revision and instructions. That transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1764CP.pdf>.

If you have questions, please contact our Provider Contact Center at our toll-free number (866) 332-7025.

Medical Director's Desk

Robert R. Kamps, M.D.

New and revised Local Coverage Determinations (LCDs) will be published or referenced in this section of the *Medicare Advisory*. LCDs contain only “reasonable and necessary” information. LCDs will not contain statutory exclusions, coding provisions, or National Coverage Determinations (NCDs). LCDs may have an accompanying article to explain coding guidelines needed to submit the claim. The *Internet-Only Manual* (IOM) needs to be referenced for the most current guidelines from CMS. The IOM can be viewed on the CMS Web site at <http://www.cms.hhs.gov/manuals>.

Within each policy, we include all applicable CPT procedure codes and ICD-9 diagnosis codes. We will publish or reference a revised policy when Medicare coverage is revised. However, *we do not publish revised medical policies solely to update a CPT procedure or ICD-9 diagnosis code that has been revised or deleted*. If a CPT or ICD-9 code is deleted and replaced with a new code, the medical policy in effect will apply to the new code. Our claims processing system will be updated with these coding changes as necessary. If you have any questions concerning a coding change, please contact the Medicare Part B Provider Call Center at 1-877-567-9232.

Providers will need to review the LCD revisions that are referenced in the LCD Updates chart. The entire revised LCD can be accessed on our Web site at <http://www.PalmettoGBA.com>. New or revised LCDs that result in coverage restrictions will become effective 45 days after publishing the information either in the *Medicare Advisory* or on the Web site. The Palmetto GBA Web site also contains the articles listing the coding guidelines for the LCDs. National coverage which includes NCDs and coverage provisions in interpretative manuals that have been assigned specific CPT/HCPCS codes and ICD-9 codes by this contractor are also listed on the Ohio/ West Virginia Palmetto GBA Web site. NCDs, LCDs and related articles are also posted on the CMS Web site at: <http://www.cms.hhs.gov/coverage>.

The Centers for Medicare & Medicaid Services (CMS) requires contractors to review all LCDs annually to ensure the LCDs remain accurate and up to date. We also review statistics to evaluate LCD effectiveness as well as whether or not we are noting any aberrant billing practices. When statistics reveal that we are not having a generalized problem with the codes that are listed in a LCD, we can elect to retire the LCD. When LCDs are retired, the services are still covered and any related NCDs or coverage listed in the IOM will continue to apply. Although a policy may be retired, services must still be “medically reasonable and necessary” (Title XVIII of the Social Security Act, section 1862(a)(1)(A)). The medical necessity for services provided must still be documented in the medical record. Claims submitted for services on or after the date the policy is retired, remain subject to monitoring by claims review, data analysis and periodic reviews. These reviews may result in Progressive Corrective Action (PCA) studies, followed by education and more intense audits of specific providers. Additionally, if data analysis shows widespread inappropriate billings, the Local Coverage Determination may be considered for reinstatement.

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Local Coverage Determination Updates

LCD	Change	Effective Date
Bone Mass Measurement 2001-37LR18	Retired (National Coverage Applies: NCD 150.3)	08/01/2009

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Reconsideration Request Form - QIC North (Ohio)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. At a minimum, **you must complete/include information for items 1, 2a, 6, 7, 11, & 12** but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

**FCSO QIC Part B North
PO Box 45208
Jacksonville, FL 32232-5208**

1. **Name of Beneficiary:** _____
- 2 a. **Medicare Number:** _____
- b. **Claim Number (ICN/DCN, if available):** _____
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")
3. **Provider Name & Number:** _____
4. **Person Appealing:** Beneficiary Provider of Service Representative
5. **Address of Person Appealing:** _____
6. **Item or service you wish to appeal:** _____
7. **Date of service: From** ____/____/____ **To** ____/____/____
8. **Does this appeal involve an overpayment?** Yes No
9. **Why do you disagree? Or, what are your reasons for your appeal? (Attach additional pages, if necessary.)** _____
10. **You may also include any supporting material to assist your appeal. Examples of supporting materials include:**
 Copy of Claim Medical Records Office Notes / Progress Notes
 Certificate of Medical Necessity Treatment Plan
11. **Printed Name of Person Appealing:** _____
12. **Signature of Person Appealing:** _____ **Date:** _____
13. **Phone Number of Person Appealing:** _____

Contractor Number: 00883

Palmetto GBA –Ohio Medicare Part B Carrier
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (866) 332-7025
A CMS Contracted Intermediary and Carrier

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Reconsideration Request Form - QIC South (West Virginia)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. At a minimum, **you must complete/include information for items 1, 2a, 6, 7, 11 & 12** but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

Q2 Administrators, LLC Part B South Operations
PO Box 183092
Columbus, Ohio 43218-3092

1. **Name of Beneficiary:** _____
- 2 a. **Medicare Number:** _____
- b. **Claim Number (ICN/DCN, if available):** _____
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")
3. **Provider Name & Number:** _____
4. **Person Appealing:** Beneficiary Provider of Service Representative
5. **Address of Person Appealing:** _____
6. **Item or service you wish to appeal:** _____
7. **Date of service: From** ____/____/____ **To** ____/____/____
8. **Does this appeal involve an overpayment?** Yes No
9. **Why do you disagree? Or, what are your reasons for your appeal? (Attach additional pages, if necessary.)** _____
10. **You may also include any supporting material to assist your appeal. Examples of supporting materials include:**
 Copy of Claim Medical Records Office Notes / Progress Notes
 Certificate of Medical Necessity Treatment Plan
11. **Printed Name of Person Appealing:** _____
12. **Signature of Person Appealing:** _____ **Date:** _____
13. **Phone Number of Person Appealing:** _____

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

The Centers for Medicare & Medicaid Services (CMS) has launched a series of education and training programs designed to leverage emerging Internet and satellite technologies to offer just-in-time training to Medicare providers and suppliers throughout the United States. Many of these programs include free, downloadable computer/Web based training courses. These courses are also available on CD-ROM.

<http://www.cms.hhs.gov/MLNGenInfo>

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Contact Center

1-866-332-7025 CSR (Toll-Free)

1-877-567-9232 IVR (Toll-Free)

FAX (614) 473-6805

TTY 1-877-391-9739

Provider Enrollment Support Line

1-866-308-5439

Electronic Data Interchange (EDI)

Technical Support

1-866-308-5438

Telephone Reopenings

1-866-308-5441

Medicare Fraud Hotline

1-888-619-5316

Medicare Beneficiary Call Center

1-800-MEDICARE (1-800-633-4227)

TTY 1-877-486-2048

FREE Training Available

To request a Medicare Provider Education meeting/ seminar at no cost to you, complete and fax the form located on the <http://www.PalmettoGBA.com/boh/Forms> or <http://www.PalmettoGBA.com/bwv/Forms>. You may also contact 1-877-567-9232 (Toll-Free).

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

<http://www.PalmettoGBA.com>

Important Sources For You

- <http://www.cms.hhs.gov>
- <http://www.cms.hhs.gov/MLNGenInfo>
- <http://www.cms.hhs.gov/CMSforms/CMSforms/list.asp>
- <http://www.cms.hhs.gov/QuarterlyProviderUpdates>
- <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

Palmetto GBA
P.O. BOX 182932
COLUMBUS OH 43218-2932

Attention: Billing Manager