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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2010, Issue 1 *www.cms.hhs.gov* *www.PalmettoGBA.com* *January 2010*

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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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Palmetto GBA Redetermination/Reopening Request Form

Palmetto GBA has revised its Redetermination/Reopening form for Part B providers to use. While not required, this form may make submitting your Part B redeterminations/reopenings easier. By using this form, all of the required elements for making a valid request are included and it will also help direct your request to the proper area quicker once received in our office.

Some differences from the current form include:

- Choices at the top of the form to identify the specific state/region
- Easier flow of information
- Comprehensive list of correct addresses to send your request

The form will be available on our Web site at http://www.PalmettoGBA.com and can be used immediately. You can download the form and type your information directly onto it! (Note: after you complete the form, it still needs to be printed and mailed to us - we do not have the ability to accept requests electronically at this time.) The form is also located at the end of this publication.

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Electronic Claims: Valid MSP Types

Medicare Secondary Payer (MSP) refers to instances in which Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. This is because the Medicare beneficiary may be entitled to other coverage, which should pay primary health benefits.

Valid MSP types that may be submitted on electronic claims:

MSP Type	Description
12	Working Aged: age 65 or over, employer's group plan has at least 20 employees
13	End Stage Renal Disease (ESRD): 30-month initial coordination period in which other insurer is primary
14	No-Fault Situations: Medicare is secondary if illness/injury results from a no fault liability.
15	Workers' Compensation (WC) situations
41	Black Lung benefits
42	Veterans Administration (VA): either Medicare or VA may pay, not both
43	Disability: under age 65, person or spouse has active employment status and employer's group plan has at least 100 employees
47	Liability Situations: Medicare is secondary if illness/injury results from a liability situation

- Submit the MSP type in loop 2000B, SBR, 05 (Insurance Type Code) field
- Always submit the type appropriate for the beneficiary's insurance coverage
- If an MSP type is submitted that does not correspond to the information Medicare has on file, your claim will be rejected. Rejected claims must be submitted as new claims.

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Interest Payment on Clean Claims Not Paid Timely

This rate is determined by the Treasury Department on a 6-month basis, effective every January 1 and July 1. For the correct rate, providers may access the Treasury Department Web page at http://fms.treas.gov/prompt/rates.html.

MCPSS Media Kit 2010

The Centers for Medicare & Medicaid Services is conducting the fifth administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). The survey is designed to collect quantifiable data on provider satisfaction with the performance of your Medicare contractor. The MCPSS will be sent to a random sample of approximately 30,000 Medicare fee-for-service providers and suppliers. CMS is listening and wants to hear from you about the services provided by your Medicare contractor. If you are selected to participate in the survey, please take a few minutes and complete this important survey. To learn more about the MCPSS, please visit http://www.cms.hhs.gov/mcpss or https://www.mcpsstudy.org.

ICD-9 Codes E000-E999: Supplementary Classification of External Causes of Injury and Poisoning

'E' diagnosis codes are supplemental to ICD-9 codes and should not be submitted as the primary or sole diagnosis on claims. Claims that contain 'E' diagnosis codes as the primary or sole diagnosis on claims are subject to denial of the service or rejection of the claim. Effective immediately, Palmetto GBA will reject services that contain only 'E' diagnosis codes as these diagnoses are not covered. Remittance Advice Remark Code MA63 "Missing/incomplete/invalid principal diagnosis" will also be sent on denied services.

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CMS Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions
- Ensure that providers have time to react and prepare for new requirements
- Announce new or changing Medicare requirements on a predictable schedule
- Communicate the specific days that CMS business will be published in the "Federal Register"

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the https://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1 (electronic mailing list).

The Quarterly Provider Update can be accessed at http://www.cms.hhs.gov/QuarterlyProviderUpdates. We encourage you to bookmark this Web site and visit it often for this valuable information.

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Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 16.0, Effective January 1, 2010

Provider Types Affected
Physicians submitting claims to Medicare Carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6728, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in October 2009.

Background
The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) Current Procedural Terminology (CPT) Manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and by
- Review of current coding practice.

The latest package of CCI edits, Version 16.0, is effective January 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present.

Additional Information
Additional information about CCI, including the current CCI and MEC edits, is available at http://www.cms.hhs.gov/NationalCorrectCodInitEd on the CMS website.

The CCI and MEC file formats are defined in the Medicare Claims Processing Manual, Chapter 23 and Section 20.9, which can be found at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS website. The official instruction (CR 6728) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1858CP.pdf on the CMS website.

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

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Annual Update of HCPCS Codes Used for Home Health (HH) Consolidated Billing Enforcement

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). Make sure your billing staff is aware of these changes.

What You Need to Know

CR6662 provides the annual HH consolidated billing update effective January 1, 2010.

The following two HCPCS codes are added to the home health consolidated billing supply code list. HCPCS code A4456 is a new code that replaces HCPCS code A4365 which is deleted below.

Added HCPCS Code	Descriptor
A4360	Disposable external urethral clamp or compression device with pad and/or pouch
A4456	Ostomy adhesive remover wipe

The following HCPCS code is deleted from the home health consolidated billing supply code list.

Deleted HCPCS Code	Descriptor
A4365	Ostomy adhesive remover wipe

Background

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the HH PPS. With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

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The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Additional Information

The official instruction (CR6662) issued to your Medicare carrier/FI/RHHI/MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1827CP.pdf on the CMS website.

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

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Claim Status Category Code and Claim Status Code Update

Note: This article was revised on December 15, 2009, to reflect a revised CR 6723 that was issued on December 14. The CR release date, transmittal number, and the Web address for accessing CR 6723 were revised. All other information remains the same.

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed

This article, based on CR6723, 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 September 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on the Internet on November 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 September 2009 committee meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on November 1, 2009. Medicare will implement those changes on January 4, 2010 as a result of CR6723.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1874CP.pdf on the CMS website.

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

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Requirements to Prevent the Misuse of HCPCS Modifiers PA, PB, and PC on Incoming Claims

Provider Types Affected

Physicians, non-physician practitioners, and hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article, based on CR 6718, advises you that the PA, PB and PC modifiers are often being submitted incorrectly on claims. This can cause incorrect denials. The Centers for Medicare & Medicaid Services (CMS) issued CR 6718 to direct contractors on handling incorrect claims in order to alleviate the issue. These detailed instructions are explained in the background section of this article. Your billing staffs need to be aware of the proper uses of the HCPCS modifiers PA, PB, and PC. The instructions are in MM6405, available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf on the CMS website.

Background

This article is based on CR 6718, which clarifies billing instructions and claims processing for information provided in a previous article MM6405. CR 6718 does not change the policy for the coverage or non-coverage of the adverse events described in MM6405.

CR 6405, "Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient," a revised version of which was issued on September 25, 2009, implemented billing procedures for these adverse events.

CMS has learned that the modifiers described in the CR 6405 are, in many cases, being submitted incorrectly by the providers. In particular, some providers are using the PC HCPCS modifier to represent the professional component of a service. This is incorrect. The PC HCPCS modifier is defined as "Wrong Surgery on a Patient." The incorrect use of this modifier results in claims being incorrectly denied. Medicare contractors will follow the requirements in CR 6718 to help prevent claims from being processed with modifiers incorrectly submitted on them.

Medicare contractors will:

- Suspend, review, and develop all claim lines that are submitted with the PA, PB, or PC modifiers; and
- Contact the provider to determine whether the claims are related to one of the adverse events as described by the HCPCS modifiers PA, PB, or PC.

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If the contractor determines that the HCPCS modifiers PA, PB, or PC have been incorrectly submitted, they will:

- Reject (return to provider) Part A outpatient claims;
- Return Part B claims as unprocessable with;
    - Claim Adjustment reason Code 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.); and
    - Remittance advice Remark Code MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.

Please submit a new claim with the complete/correct information.

Additional Information

The official instruction, CR 6718, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1867CP.pdf on the CMS website.

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

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Repeat or Duplicate Services on the Same Day

Claims for multiple, identical services provided to an individual patient on the same day may be denied as duplicate claims if Palmetto GBA cannot determine that these services have been performed more than one time. Filing claims properly the first time will reduce your need to appeal those denials and improve your cash flow.

Many providers and billing departments re-file claims without allowing sufficient time for the original claim to process. One submission is all that is required. If you have not received payment after 30 days and are concerned about your payment, contact Palmetto GBA via the toll-free line to check the status of a claim through the provider IVR system at (877) 567-9232 or you may use other electronic claims status inquiry functions available.

When a correction is needed on a previously paid service, do not submit as a new claim. Palmetto GBA can "reopen" these claims, at your request. Please write to:

Palmetto GBA
Redeterminations/Reopenings
QA-555
P.O. Box 182933
Columbus, OH 43218-2933

Minor claim corrections can also be reopened by calling our telephone reopening line at our toll-free number, (866) 308-5441, or phone the Provider Contact Center at (866) 332-7025.

To ensure correct processing of your claims, please consider the following:

- Submit services on one claim using the Days/Units field.
- Submit multiple, identical services on the same claim. If you submit more than one claim for the same service, you can expect identical services to be denied.

The most effective method to ensure timely processing is to use the Days/Units Field and submit all services on one claim.

Example:
Patient receives two chest x-rays on October 1, 2009, interpreted by the *same physician.* The first interpretation is performed at 10:00 a.m. and the interpretation of the second x-ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/09	71010-26	2

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Modifiers:
Failure to submit appropriate modifiers may result in delay of payment or denial of service(s). When a modifier is used to indicate a repeat service, the first such service should be submitted without the modifier and the repeated service(s) should include the modifier.

Site Modifiers:
Use the appropriate site HCPCS modifier (RT, LT, T1, etc) if available.

Example:
Patient received a percutaneous tenotomy on the second digit and the fourth digit of the left foot by the same physician on the same day.

Submit as:

Date of Service	CPT Code/HCPCS Modifier	Days/Units
10/1/2009	28010-T1	1
10/1/2009	28010-T3	1

Identical services being repeated should be submitted using CPT modifier 76, 77, or 91.

- **CPT Modifier 76 – "Repeat procedure by same physician"** The physician may need to indicate that a service was repeated the same day subsequent to the original service. This modifier indicates the difference between duplicate services and repeated services.

Example:
Patient receives three chest x-rays on October 1, 2009, by the same physician. The first x-ray is performed at 10:00 a.m., the next one at 12:00 p.m., and a follow-up is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code	Days/Units
10/1/2009	71020	3

OR submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/2009	71020	1
10/1/2009	71020-76	2

- **CPT Modifier 77 – "Repeat procedure by another physician":** A physician may need to indicate that he or she repeated a service performed by *another physician* on the same day.

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Example:
Patient receives two EKGs on October 1, 2009. The first EKG is taken at 10:00 a.m. and Dr. A. performs the interpretation. The second EKG is taken at 1:30 p.m. and Dr. B performs the interpretation.

Submit as:
Claim #1 – Dr. A

Date of Service	CPT Code	Days/Units
10/1/2009	93010	1

Claim #2 – Dr. B

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/2009	93010-77	1

- **CPT Modifier 91 – "Repeat clinical diagnostic laboratory test":** It may be necessary to repeat the same laboratory test on the same day to obtain multiple test results. CPT modifier 91 should be used in this case. This modifier may not be used when tests are repeated to confirm the initial results due to testing problems with equipment or specimens. Tests that include multiple specimens being collected at different times (e.g. glucose tolerance) should be submitted using the appropriate code for the test and should not be submitted as repeated tests.

Example:
The patient had two Hematocrit blood count tests performed on the same day.

Submit as:

Date of Service	CPT Code	Days/Units
10/1/2009	85014	2

Or Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/2009	85014	1
10/1/2009	85014-91	1

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Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update

Provider Types Affected

This article is for physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 6742, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). The CR is effective January 1, 2010. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month. A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early March, July, and November. Both code lists are posted at http://www.wpc-edi.com/Codes on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6742.

CMS has also developed a tool to help you search for a specific category of code and that tool is available at http://www.cmsremarkcodes.info on the Internet. Note that this website does not replace the Washington Publishing Company (WPC) site. That site is http://www.wpc-edi.com/Codes and, should there be any discrepancies in what is posted at the CMS site and the WPC site; consider the WPC site to be correct.

Additional Information

To see the official instruction (CR6742) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1862CP.pdf on the CMS website.

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

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New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
232	Institutional transfer amount. Note: Applies to Institutional claims only and explains the DRG amount differences when patients care crosses multiple institutions	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro- Eligibility – Must also include Remittance Advice Remark Code	11/1/2009

Modified Codes - CARC

Code	Current Modified Narrative	Effective Date Per WPC Posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

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Code	Current Modified Narrative	Effective Date Per WPC Posting
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/ specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

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Code	Current Modified Narrative	Effective Date Per WPC Posting
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance AdviceRemark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/ allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010

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Code	Current Modified Narrative	Effective Date Per WPC Posting
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/ order the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

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Code	Current Modified Narrative	Effective Date Per WPC Posting
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an “Alert”.)	7/1/2010

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Code	Current Modified Narrative	Effective Date Per WPC Posting
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided ((may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 07/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.	7/1/2010

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Deactivated Codes - CARC

Code	Current Narrative	Effective Date
87	Transfer Amount	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	1/1/2012

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N521	Mismatch between the submitted provider information and the provider information stored in our system.	NO
N522	Duplicate of a claim processed as a crossover claim.	NO

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	NO
M118	Letter to follow containing further information.	NO
N59	Please refer to your provider manual for additional program and provider information.	NO
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	NO
N202	Additional information/explanation will be sent separately.	NO

Deactivated Codes – RARC

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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)

	Ambulance		Federally Qualified Health Center		Physical/Occupational Therapy
	Ambulatory Surgical Center		General - Part B		Physician
	Anesthesia/Pain Management		Gynecology		Podiatry
	Cardiovascular		Hematology/Oncology		Primary Care
	Chiropractic		Independent Diagnostic Testing Facilities		Psychology/Psychiatry
	Community Mental Health Center		Nephrology		Radiology
	Diagnostic Tests		Non-Physician Practitioners		Surgery
	Drugs/Biologicals		Ophthalmology/Optometry		
	Electronic Date Interchange (EDI)		Pathology & Laboratory		

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Expansion of the Current Scope of Editing for Ordering/Referring Providers for claims processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)

Note: This article was revised on December 11, 2009 to reflect an extension of phase 1 and a delay in implementing phase 2 of CR 6417. All other information remains the same.

Provider Types Affected

Physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare Administrative Contractors (MACs) for items or services that were ordered or referred. (A separate Article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421. That article is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf on the CMS website.)

Provider Action Needed

This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty that is eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Background

CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and non-physician practitioners meet the definitions at section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Chiropractic Medicine;

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- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key Points

- During Phase 1 (October 5, 2009-April 4, 2010): If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice.
- During Phase 2, (April 5, 2010 and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS website. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

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PLEASE NOTE: The changes being implemented with CR 6417 do 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.

Additional Information
You can find the official instruction, CR6417, issued to your carrier or B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R572OTN.pdf on the CMS website.

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

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Revisions to Consultation Services Payment Policy

Note: This article was revised on December 17, 2009, to correct the "initial hospital day codes" referenced on the top of page 4 (in bold). Those codes should be 99221-99223. The error listed them as 99231-99233. All other information remains the same.

Provider Types Affected

This article is for physicians and non-physician practitioners (NPPs) who perform the initial evaluation and management (E/M) consultation for Medicare beneficiaries and submit claims to Medicare Carriers, Fiscal Intermediaries, and/or Medicare Administrative Contractors (MACs) for those services. It is also intended for Method II critical access hospitals, which bill for the services of those physician and non-physician practitioners who have reassigned their billing rights. This article only applies to physicians billing the Medicare fee-for-service program. It does not apply to Medicare Advantage or non-Medicare insurers.

Provider Action Needed

This article pertains to Change Request (CR) 6740, which alerts providers that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents WHERE the visit occurs and that identify the COMPLEXITY of the visit performed. See the Key Points section of this article for details.

Background

In the calendar year 2010 Medicare Physician Fee Schedule (MPFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G HCPCS codes. The change will not increase or decrease Medicare payments. In place of the consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in the Medicare Claims Processing Manual, Chapter 12, Section 30.6 that pertain to the use of the American Medical Association (AMA) Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are removed by CR 6740. (The Web address for viewing CR 6740 is in the Additional Information section of this article.)

Key Points of CR 6740

- Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA CPT consultation codes (ranges 99241-99245, and 99251-99255) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings.

- Effective January 1, 2010, local FIs and/or A/B MACs will no longer recognize AMA CPT consultation codes (ranges 99241-99245, and 99251-99255) for Method II CAHs, when billing for

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the services of those physician and non-physician practitioners who have reassigned their billing rights.

- Physicians may employ the 2009 consultation service codes, where appropriate, to bill for consultative services furnished up to and including December 31, 2009.

- Physicians who bill a consultation after January 1, 2010, will have the claim returned with a message indicating that Medicare uses another code for the service. The physician must bill another code for the service and may not bill the patient for a non-covered service.

- RHCs and FQHCs will discontinue use of AMA CPT consultation codes 99241-99245 and 99251-99255 and should instead use CPT codes 99201-99215 and 99304-99306.

- Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.

- In the inpatient hospital setting and nursing facility setting, any physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (CPT code 99221 – 99223) or nursing facility care visit code (CPT 99304 – 99306), where appropriate.

- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.

- The principal physician of record will append HCPCS modifier "-AI" Principal Physician of Record, to the E/M code when billed. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient will bill only the E/M code for the complexity level performed.

- However, claims that include the "-AI" HCPCS modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.

- For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report CPT codes 99217-99220. In the event another physician evaluation is necessary, the physician who provides the additional evaluation bills the office or other outpatient visit codes when they provide services to the patient.

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- For example, if an internist orders observation services, furnishes the initial evaluation, and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established patient office or other outpatient visit codes as appropriate.

- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients and who are discharged on the same date, the physician should report CPT codes 99234-99236 (e.g. code 99234- Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date). If the patient is an inpatient and another physician evaluation is necessary, the physician would bill the initial hospital day code as appropriate (CPT codes 99221-99223). Otherwise, physician should use the new or established patient office or other outpatient visit codes for a necessary evaluation.

- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients on the same date, the physician should report only the initial hospital care services codes (CPT codes 99221 - 99223). Medicare will pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., CPT code 99221) for the initial hospital admission. Medicare will pay the office visit as billed and the Level 1 initial hospital care code. The principal physician of record, as previously noted, must append the "-AI" HCPCS modifier to the claim with the initial hospital care code.

- For patients receiving hospital outpatient observation services or inpatient care services (including admission and discharge services) for whom observation services are initiated or the hospital inpatient admission begins on the same date as the patient's discharge, the ordering physician should report CPT codes 99234-99236.

- Emergency department visits (CPT codes 99281 - 99288)-- physician billing for emergency department services provided to patient by both patient's personal physician and emergency department (ED) physician. If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill.

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- If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

- Follow-up visits by the physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities, as is the current policy.

- In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.

- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years. Examples of where a new patient office is not billable:

- If the consultant furnishes a pre-operative consultation at the request of a surgeon on a beneficiary, the consultant has provided a professional service to the patient within the past three years and would not meet the requirements to bill a new patient office visit.

- The consultant could not bill for a new patient office visit for a consultation furnished to a known beneficiary for a different diagnosis than he or she has previously treated if the patient was seen by the consultant in the prior three years.

- The consultant furnishes a consultation to a known beneficiary in an outpatient setting different than the office (e.g. emergency department, observation where the patient was seen in the past three years). As the patient has been seen by the consultant within the past three years, a new patient office visit cannot be billed.

- In order for physicians to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

- Medicare may pay for an inpatient hospital visit or an office or other outpatient visit if one physician or qualified NPP in a group practice requests an evaluation and management service from another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge.

- Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code

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for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

- Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or

- Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Note: The first option may be easier from a billing and claims processing perspective.

- All physicians and qualified NPPs need to follow the E/M documentation guidelines, which are available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.

- Medicare contractors will use the following threshold times to determine if the prolonged services CPT codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes. Threshold time for prolonged visit CPT codes 99354 and/or 99355 billed with office outpatient visit are as follows (all times in minutes):

CPT Code	**Typical Time for Code**	**Threshold Time to Bill CPT Code 99354**	**Threshold Time to Bill CPT Codes 99354 and 99355**
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120

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CPT Code	Typical Time for Code	Threshold Time to Bill CPT Code 99354	Threshold Time to Bill CPT Codes 99354 and 99355
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

- Threshold time for prolonged visit CPT codes 99356 and/or 99357 billed with inpatient setting codes are as follows (all times in minutes):

CPT Code	Typical Time for Code	Threshold Time to Bill CPT Code 99356	Threshold Time to Bill CPT Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110

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CPT Code	Typical Time for Code	Threshold Time to Bill CPT Code 99356	Threshold Time to Bill CPT Codes 99356 and 99357
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

- Appropriate documentation is required to support the billing of the prolonged visit codes.
- The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the Medicare Claims Processing Manual, Chapter 12, 30.6.15.1.C, provides that physicians may count only the duration of direct face-to-face contact between the physician and the patient for these purposes, and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient,

Additional Information

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

The official instruction, CR 6740, issued to Medicare MACs and carriers regarding this change may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf on the CMS website.

The E/M documentation guidelines are available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.

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Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2010

Provider Types Affected

This article is for providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for those services.

What You Need to Know

Change Request (CR) 6631, from which this article is taken, provides the AIF for CY 2010. The AIF for CY 2010 is zero (0).

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2010 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the AIF.

The following table displays the AIF for CY 2010 and for the previous 7 years.

Ambulance Inflation Factor by CY	
Year	**Percentage of Inflation**
2010	0.0%
2009	5.0%
2008	2.7%
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

Additional Information

The official instruction, CR 6631, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1861CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

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

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January 2010 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected
This article has information for Ambulatory Surgical Centers (ASC) that submit claims to Medicare Administrative Contractors (MACs) or carriers for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 6746 and is a recurring update that describes changes to, and billing instructions for, various payment policies implemented in the January 2010 ASC update. It also includes updates to the Healthcare Common Procedure Coding System (HCPCS), and to the Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers).Make sure that your billing staff is aware of the changes that are described in detail, below.

Background
Included in CR 6746 are CY 2010 payment rates for separately payable drugs and biologicals, including short descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2010 ASC payment rates for covered surgical and ancillary services (ASCFS file). In addition, it includes the following updates to the Medicare Claims processing

Manual ASC Chapter (Chapter 14):
- Section 10.1 to reflect revised 42 CFR 416.30, which clarifies Centers for Medicare & Medicaid Services (CMS) policy related to the ability of ASCs that are operated by hospitals to become provider-based outpatient departments; and
- Section 40.9 to update ASC payment and billing policies for insertion of a new technology intraocular lens (NTIOL) that is also an approved astigmatism-correcting intraocular lens (A-C IOL) or presbyopia-correcting intraocular lens (P-C IOL), concurrent with cataract extraction.

Updated Core Based Statistical Areas (CBSA)
Table 1 below shows updates to eight CBSAs recognized by the CMS for ASC claims with dates of service on and after January 1, 2010.

Table 1
January 1, 2010 Core Based Statistical Area (CBSA) Changes

COUNTY/STATE	FIPS CODE	2009 CBSA	2010 CBSA
Alexander, IL	17003	14	16020
Geary, KS	20061	17	31740
Pottawatomie, KS	20149	17	31740

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COUNTY/STATE	FIPS CODE	2009 CBSA	2010 CBSA
Riley, KS	20161	17	31740
Blue Earth, MN	27013	24	31860
Nicollet, MN	27103	24	31860
Bollinger, MO	29017	26	16020
Cape Girardeau, MO	29031	26	16020

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective January 1, 2010

In the CY 2010 OPPS/ASC final rule with comment period, it was stated that payments for separately payable drugs and biologicals based on the average sales prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2010, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2010 outpatient prospective payment system (OPPS)/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2009. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2010 release of the ASC DRUG file.

You can find the updated payment rates effective January 1, 2010 for covered ancillary drugs and biologicals in the January 2010 update of the ASC Addendum BB at http://www.cms.hhs.gov/ASCPayment/ASCRN/ItemDetail.asp?ItemID=CMS1216691 on the CMS website.

New HCPCS Codes for Drugs and Biologicals that are Separately Payable under the ASC Payment System as of January 1, 2010

For CY 2010, new Level II HCPCS codes have been created for reporting specific drugs and biologicals. Twenty-three of the new Level II HCPCS codes for reporting drugs and biologicals are separately payable to ASCs for dates of service on or after January 1, 2010. The new Level II HCPCS codes, their payment indicators, and short descriptors are displayed in Table 2, below, and are included in the January 2010 ASC DRUG file.

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Table 2
New Level II HCPCS Codes for Drugs and Biologicals
Separately Payable under the ASC Payment System for CY 2010

CY 2010 HCPCS Code	CY 2010 Payment Indicator	Short Descriptor
A9581	K2	Gadoxetate disodium inj
A9582	K2	Iodine I-123 iobenguane
A9583	K2	Gadofosveset trisodium inj
C9254	K2	Injection, lacosamide
C9255	K2	Paliperidone palmitate inj
C9256	K2	Dexamethasone intravitreal
C9257	K2	Bevacizumab injection
J0586	K2	AbobotulinumtoxintypeA
J0598	K2	C1 esterase inhibitor inj
J0718	K2	Certolizumab pegol inj
J0833	K2	Cosyntropin injection NOS
J0834	K2	Cosyntropin cortrosyn inj
J1680	K2	Human fibrinogen conc inj
J2562	K2	Plerixafor injection
J2793	K2	Rilonacept injection
J2796	K2	Romiplostim injection
J7185	K2	Xyntha inj
J7325	K2	Synvisc or Synvisc-One
J9155	K2	Degarelix injection
J9171	K2	Docetaxel injection
J9328	K2	Temozolomide injection
Q0138	K2	Ferumoxytol, non-esrd
Q9968	K2	Visualization adjunct

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Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009

The payment rates for three HCPCS codes were incorrect in the April 2009 ASC DRUG file. The corrected payment rates are listed in Table 3, below, and have been included in the revised April 2009 ASC DRUG file effective for services furnished on April 1, 2009 through implementation of the July 2009 update. If you believe that have received an incorrect payment on claims processed between April 1, 2009 and June 30, 2009, you may request your carrier or MAC to adjust those claims.

Table 3
Updated Payment Rates for Certain HCPCS Codes
Effective April 1, 2009 through June 30, 2009

HCPCS Code	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9245	Injection, romiplostim	$44.81	$8.79
J1260	Dolasetron mesylate	$4.54	$0.91
J2778	Ranibizumab injection	$399.55	$79.91

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

The payment rates for three HCPCS codes were incorrect in the July 2009 ASC DRUG file. The corrected payment rates are listed in Table 4, below, and have been included in the revised July 2009 ASC DRUG file effective for services furnished on July 1, 2009 through implementation of the October 2009 update. If you believe that you may have received an incorrect payment on claims processed between July 1, 2009 and September 30, 2009, you may ask your carrier or MAC to adjust those claims.

Table 4
Updated Payment Rates for Certain HCPCS Codes
Effective July 1, 2009 through September 30, 2009

HCPCS Code	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9354	Veritas collagen matrix, cm2	$11.77	$2.31
C9364	Porcine implant, Permacol	$18.46	$3.62
J1520	Gamma globulin 7 CC inj	$102.15	$20.43

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Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

When billing for a biological for which the HCPCS code describes a product that is solely surgically implanted or inserted (and that is separately payable under the ASC payment system) you should report the HCPCS code for the product. However, if the implanted biological is packaged (that is, not eligible for separate payment under the ASC payment system) you should not report the biological product HCPCS code.

When billing for a biological for which the HCPCS code describes a product that may be either surgically implanted or inserted or otherwise applied in the care of a patient, you should not report the HCPCS code for the product when the biological is used as an implantable device (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures.

Under the ASC payment system, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items. When using biologicals during surgical procedures as implantable devices, you may include the charges for these items in your charge for the procedure.

Medicare Claims Processing Manual Updates for ASC Terms of Agreement with CMS

1. In addition to the information above, CR 6746 also provides updates to the Medicare Claims Processing Manual, Chapter 14 in the following sections: Section 10.1 Update Information

   This updated policy provides that a hospital-operated facility has the option of being considered by Medicare either to be an ASC or to be a provider-based department of the hospital as defined in 42 CFR 413.65.

   It further provides that:

   - A hospital-operated facility that decides to discontinue participation in Medicare as an ASC must terminate its ASC agreement with CMS, complying with guidance provided in 42 CFR 416.35 (either by sending written notice to CMS or by ceasing to furnish services to the community); and

   - To participate in Medicare as a provider-based department of the hospital, the hospital must comply with CMS requirements to certify the hospital-operated facility as a provider-based department of the hospital as described in 42 CFR 413.65, including meeting all of the hospital conditions of participation specified in 42 CFR 482.

2. Section 40.9 Update Information

   This update provides that (effective for services on and after January 1, 2010), you are to use three separate codes to bill for the insertion of a Category 3 new technology intraocular lens (NTIOL) (concurrent with cataract extraction), that is also an approved Astigmatism-correcting (A-C) intraocular lens (IOL) or Presbyopia-correcting (P-C) IOL.

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- To report charges associated with the non-covered functionality of the A-C IOL or P-C IOL, you should use HCPCS code V2787 (Astigmatism-correcting function of intraocular lens) or V2788 (Presbyopia-correcting function of intraocular lens), as appropriate;

- To report the covered cataract extraction and insertion procedure, you should use the appropriate CPT code: 1) 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), and complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage); 2) CPT code 66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)); or 3) CPT code 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)), and

- To report the covered NTIOL aspect of the lens on claims for insertion of an A-C IOL or P-C IOL that is also designated as an NTIOL, you should use HCPCS code Q1003 (New technology, intraocular lens, category 3 (reduced spherical aberration) as defined in Federal Register notice, Vol. 65, dated May 3, 2000.

Note: A Listing of the CMS-approved Category 3 NTIOLs, A-C IOLs, and P-C IOLs are available at http://www.cms.hhs.gov/ASCPayment/ on the CMS website.

CR 6746 also provides updates for when a device is furnished with no cost, or with full or partial credit. For CY 2010, CMS updated the list of ASC-covered device intensive procedures and devices that are subject to the no cost/full credit and partial credit device adjustment policy. You should be aware that your carrier or MAC will reduce the payment for the device implantation procedures listed in Table 6 (CR 6746, Attachment B), below, by the full device offset amount for no cost/full credit cases.

Further, you must append the HCPCS modifier FB to the HCPCS procedure code when the device that is furnished without cost or with full credit is listed in Table 7 (CR 6746, Attachment C), below, and the associated implantation procedure code is listed in Table 6 below.

Finally, your carrier or MAC will reduce the payment for implantation procedures listed in Table 6 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost.

If you receive a partial credit of 50 percent or more of the cost of a device listed in Table 7, you must append the HCPCS modifier FC to the associated implantation procedure code if the procedure is listed in Attachment B. You should not submit a single procedure code with both HCPCS modifiers FB and FC.

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You can find more information about billing for procedures involving no cost/full credit and partial credit devices in the Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers), Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008) at http://www.cms.hhs.gov/manuals/downloads/clm104c14.pdf on the CMS website.

CR 6746, attachment A lists the surgical procedures and ancillary services that are newly payable in the ASC setting as of January 1, 2010. Those procedures are displayed here in Table 5 as follows.

Table 5
ASC Covered Surgical Procedures and Ancillary Services that are Newly Payable in ASCs Effective
CY 2010

CPT Code	Short Descriptor
0193T	Rf bladder neck microremodel
0213T	Us facet jt inj cerv/t 1 lev
0214T	Us facet jt inj cerv/t 2 lev
0215T	Us facet jt inj cerv/t 3 lev
0216T	Us facet jt inj ls 1 level
0217T	Us facet jt inj ls 2 level
0218T	Us facet jt inj ls 3 level
14301	Skin tissue rearrangement
14302	Skin tissue rearrange add-on
21011	Exc face les sc < 2 cm
21012	Exc face les sc = 2 cm
21013	Exc face tum deep < 2 cm
21014	Exc face tum deep = 2 cm
21016	Resect face tum = 2 cm
21552	Exc neck les sc = 3 cm
21554	Exc neck tum deep = 5 cm
21558	Resect neck tum = 5 cm
21931	Exc back les sc = 3 cm
21932	Exc back tum deep < 5 cm
21933	Exc back tum deep = 5 cm

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CPT Code	Short Descriptor
21936	Resect back tum = 5 cm
22901	Exc back tum deep = 5 cm
22902	Exc abd les sc < 3 cm
22903	Exc abd les sc > 3 cm
22904	Resect abd tum < 5 cm
22905	Resect abd tum > 5 cm
23071	Exc shoulder les sc > 3 cm
23073	Exc shoulder tum deep > 5 cm
23078	Resect shoulder tum > 5 cm
24071	Exc arm/elbow les sc = 3 cm
24073	Ex arm/elbow tum deep > 5 cm
24079	Resect arm/elbow tum > 5 cm
25071	Exc forearm les sc > 3 cm
25073	Exc forearm tum deep = 3 cm
25078	Resect forearm/wrist tum=3cm
26037	Decompress fingers/hand
26111	Exc hand les sc > 1.5 cm
26113	Exc hand tum deep > 1.5 cm
26118	Exc hand tum ra > 3 cm
27043	Exc hip pelvis les sc > 3 cm
27045	Exc hip/pelv tum deep > 5 cm
27059	Resect hip/pelv tum > 5 cm
27337	Exc thigh/knee les sc > 3 cm
27339	Exc thigh/knee tum deep >5cm
27364	Resect thigh/knee tum >5 cm
27475	Surgery to stop leg growth
27479	Surgery to stop leg growth
27616	Resect leg/ankle tum > 5 cm
27632	Exc leg/ankle les sc > 3 cm
27634	Exc leg/ankle tum deep >5 cm

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CPT Code	Short Descriptor
27720	Repair of tibia
28039	Exc foot/toe tum sc > 1.5 cm
28041	Exc foot/toe tum deep >1.5cm
28047	Resect foot/toe tumor > 3 cm
29581	Apply multlay comprs lwr leg
31626	Bronchoscopy w/markers
32552	Remove lung catheter
32553	Ins mark thor for rt perq
35460	Repair venous blockage
35475	Repair arterial blockage
36147	Access av dial grft for eval
37761	Ligate leg veins open
41512	Tongue suspension
42225	Reconstruct cleft palate
42227	Lengthening of palate
43130	Removal of esophagus pouch
43752	Nasal/orogastric w/stent
45171	Exc rect tum transanal part
45172	Exc rect tum transanal full
45541	Correct rectal prolapse
46707	Repair anorectal fist w/plug
49411	Ins mark abd/pel for rt perq
49435	Insert subq exten to ip cath
49436	Embedded ip cath exit-site
49442	Place cecostomy tube perc
50080	Removal of kidney stone
50081	Removal of kidney stone
50727	Revise ureter
51535	Repair of ureter lesion
51727	Cystometrogram w/up

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CPT Code	Short Descriptor
51728	Cystometrogram w/vp
51729	Cystometrogram w/vp&up
53855	Insert prost urethral stent
57295	Revise vag graft via vagina
57426	Revise prosth vag graft lap
60210	Partial thyroid excision
60212	Partial thyroid excision
60220	Partial removal of thyroid
60225	Partial removal of thyroid
61770	Incise skull for treatment
63661	Remove spine eltrd perq aray
63662	Remove spine eltrd plate
63663	Revise spine eltrd perq aray
63664	Revise spine eltrd plate
64490	Inj paravert f jnt c/t 1 lev
64491	Inj paravert f jnt c/t 2 lev
64492	Inj paravert f jnt c/t 3 lev
64493	Inj paravert f jnt l/s 1 lev
64494	Inj paravert f jnt l/s 2 lev
64495	Inj paravert f jnt l/s 3 lev
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
77338	Design mlc device for imrt
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing

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CPT Code	Short Descriptor
78454	Ht musc image, planar, mult
90476	Adenovirus vaccine, type 4
90680	Rotovirus vacc 3 dose, oral
90725	Cholera vaccine, injectable
90735	Encephalitis vaccine, sc

HCPCS Code	Short Descriptor
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C9254	Injection, lacosamide
C9255	Paliperidone palmitate inj
C9256	Dexamethasone intravitreal
C9257	Bevacizumab injection
J0586	AbobotulinumtoxintypeA
J0598	C1 esterase inhibitor inj
J0718	Certolizumab pegol inj
J0833	Cosyntropin injection NOS
J0834	Cosyntropin cortrosyn inj
J0945	Brompheniramine maleate inj
J1324	Enfuvirtide injection
J1680	Human fibrinogen conc inj
J1817	Insulin for insulin pump use
J2320	Nandrolone decanoate 50 MG
J2321	Nandrolone decanoate 100 MG
J2322	Nandrolone decanoate 200 MG
J2562	Plerixafor injection
J2793	Rilonacept injection
J2796	Romiplostim injection
J7185	Xyntha inj

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HCPCS Code	Short Descriptor
J7197	Antithrombin iii injection
J7325	Synvisc or Synvisc-One
J7515	Cyclosporine oral 25 mg
J9155	Degarelix injection
J9171	Docetaxel injection
J9212	Interferon alfacon-1 inj
J9328	Temozolomide injection
Q0138	Ferumoxytol, non-esrd
Q2004	Bladder calculi irrig sol
Q9968	Visualization adjunct

Table 6
CY 2010 ASC Covered Surgical Procedures to Which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Applies

CPT Code	Short Descriptor	CY2010 Device Offset Amount for No Cost/ Full Credit Case	CY2010 Device Offset Amount for Partial Credit Case
24361	Reconstruct elbow joint	$4,607.23	$2,303.62
24363	Replace elbow joint	$4,607.23	$2,303.62
24366	Reconstruct head of radius	$4,607.23	$2,303.62
25441	Reconstruct wrist joint	$4,607.23	$2,303.62
25442	Reconstruct wrist joint	$4,607.23	$2,303.62
25446	Wrist replacement	$4,607.23	$2,303.62
27446	Revision of knee joint	$4,607.23	$2,303.62
33206	Insertion of heart pacemaker	$5,750.42	$2,875.21
33207	Insertion of heart pacemaker	$5,750.42	$2,875.21
33208	Insertion of heart pacemaker	$7,169.69	$3,584.85
33212	Insertion of pulse generator	$4,925.26	$2,462.63
33213	Insertion of pulse generator	$5,451.67	$2,725.84

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CPT Code	Short Descriptor	CY2010 Device Offset Amount for No Cost/ Full Credit Case	CY2010 Device Offset Amount for Partial Credit Case
33214	Upgrade of pacemaker system	$7,169.69	$3,584.85
33224	Insert pacing lead & connect	$11,169.79	$5,584.90
33225	Lventric pacing lead add-on	$11,169.79	$5,584.90
33240	Insert pulse generator	$19,533.73	$9,766.87
33249	Eltrd/insert pace-defib	$24,535.85	$12,267.93
33282	Implant pat-active ht record	$3,833.98	$1,916.99
53440	Male sling procedure	$3,915.41	$1,957.71
53444	Insert tandem cuff	$3,915.41	$1,957.71
53445	Insert uro/ves nck sphincter	$7,812.01	$3,906.01
53447	Remove/replace ur sphincter	$7,812.01	$3,906.01
54400	Insert semi-rigid prosthesis	$3,915.41	$1,957.71
54401	Insert self-contd prosthesis	$7,812.01	$3,906.01
54405	Insert multi-comp penis pros	$7,812.01	$3,906.01
54410	Remove/replace penis prosth	$7,812.01	$3,906.01
54416	Remv/repl penis contain pros	$7,812.01	$3,906.01
61885	Insrt/redo neurostim 1 array	$11,868.32	$5,934.16
61886	Implant neurostim arrays	$16,331.99	$8,166.00
62361	Implant spine infusion pump	$11,071.42	$5,535.71
62362	Implant spine infusion pump	$11,071.42	$5,535.71
63650	Implant neuroelectrodes	$2,553.00	$1,276.50
63655	Implant neuroelectrodes	$3,707.26	$1,853.63
63685	Insrt/redo spine n generator	$11,868.32	$5,934.16
64553	Implant neuroelectrodes	$2,553.00	$1,276.50
64555	Implant neuroelectrodes	$2,553.00	$1,276.50
64560	Implant neuroelectrodes	$2,553.00	$1,276.50
64561	Implant neuroelectrodes	$2,553.00	$1,276.50
64565	Implant neuroelectrodes	$2,553.00	$1,276.50
64573	Implant neuroelectrodes	$7,779.06	$3,889.53

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CPT Code	Short Descriptor	CY2010 Device Offset Amount for No Cost/ Full Credit Case	CY2010 Device Offset Amount for Partial Credit Case
64575	Implant neuroelectrodes	$3,707.26	$1,853.63
64577	Implant neuroelectrodes	$3,707.26	$1,853.63
64580	Implant neuroelectrodes	$3,707.26	$1,853.63
64581	Implant neuroelectrodes	$3,707.26	$1,853.63
64590	Insrt/redo pn/gastr stimul	$11,868.32	$5,934.16
69714	Implant temple bone w/stimul	$4,607.23	$2,303.62
69715	Temple bne implnt w/stimulat	$4,607.23	$2,303.62
69717	Temple bone implant revision	$4,607.23	$2,303.62
69718	Revise temple bone implant	$4,607.23	$2,303.62
69930	Implant cochlear device	$24,434.36	$12,217.18

Table 7
CY 2010 Devices for Which HCPCS Modifier FB or FC Must be Reported with the Procedure Code When Furnished at No Cost or With Full or Partial Credit

HCPCS Code	Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab

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HCPCS Code	Short Descriptor
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

Additional Information

You can find the official instruction, CR 6746, issued to your carrier or MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1865CP.pdf on the CMS website.

You will find the updates to the Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers), Sections 10.1 (Definition of Ambulatory Surgical Center (ASC)) and 40.9 (Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)) as an attachment to CR 6746.

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

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MIPPA Section 139 Teaching Anesthesiologists

Note: This article was revised on December 15, 2009; to clarify the language on page 4 regarding teaching CRNA's billing two concurrent cases with student nurse anesthetists on or after January 1, 2010. All other information remains the same.

Provider Types Affected

Anesthesiologists and Certified Registered Nurse Anesthetists (CRNA) need to know about this issue if they bill Medicare carriers and/or Medicare Administrative Contractors (A/B MAC) for providing teaching anesthesia services for anesthesia residents and student nurse anesthetists.

What You Need to Know

CR 6706, from which this article is taken, implements Section 139 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). This section of MIPPA: 1) Establishes a special payment rule for teaching anesthesiologists (effective for services furnished on or after January 1, 2010); 2) Specifies the periods during which the teaching anesthesiologist must be present during the procedure in order to receive payment based on the regular anesthesia fee schedule amount; and 3) Provides the Secretary of Health and Human Services (HHS) a directive that addresses payments for the anesthesia services of teaching certified registered nurse anesthetists (CRNA).

Please see the Background section, below, for details.

Background

Teaching Anesthesiologist Payment

For anesthesia services furnished prior to January 1, 2010, payment for the services of a teaching anesthesiologist involved in cases with anesthesia residents was determined in the following manner:

- If the teaching anesthesiologist was involved in a single case with an anesthesia resident, and satisfied the criteria in the Medicare Claims.
- Processing Manual, Chapter 12 (Physicians/Non-physician Practitioners), section 100.1 (Payment for Physician Services in Teaching Settings Under the MPFS), payment could made based on the anesthesia fee schedule amount, which would be the same as if the anesthesiologist performed the anesthesia case alone.
- If the anesthesiologist medically directed the provision of anesthesia services in two, three or four concurrent cases and any of which involved residents, then payment was made for the physician's involvement in the resident case(s) under the medical direction payment policy. Under this policy, payment for the anesthesiologist service would be based on 50% of the anesthesia fee schedule that would apply if the anesthesiologist performed the cases alone.

CR 6706, from which this article is taken, announces a change to this payment policy for teaching anesthesiologists, through the implementation of Section 139 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

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Specifically, (effective for anesthesia services furnished on or after January 1, 2010) payment may be made to a teaching anesthesiologist under the Medicare physician fee schedule, at the regular fee schedule level, if he or she is involved in the training of residents in a single anesthesia case, two concurrent cases, or in a single case that is concurrent to another case paid under the medical direction rules.

Note: The medical direction payment policy would apply to the concurrent case (above) if it involves a CRNA, Anesthesia Assistant (AA), or student nurse anesthetist.

In order for this special payment rule to apply: 1) The teaching anesthesiologist (or different anesthesiologists in the same physician group) must be present during all critical or key portions of the anesthesia service; 2) If different teaching anesthesiologists in the anesthesia group are present during the key or critical periods, the performing physician (for purposes of claims reporting) is the teaching anesthesiologist who started the case; and 3) The teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.

Note: If more than one teaching anesthesiologist in the anesthesia group is present during the key or critical periods, the National Provider Identifier (NPI) of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim. A teaching anesthesiologist in a group practice would put his/her NPI in field #24 (as the rendering physician) and the NPI of the group would go in field #33.

Finally, the patient's medical record documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary. The teaching anesthesiologist should use the AA HCPCS modifier (Anesthesia services performed personally by anesthesiologist) and the GC HCPCS certification modifier (The Teaching Physician was present during the key portion of the service and was immediately available during other parts of the service) to report such cases.

Anesthesia Services and Teaching CRNAs

CR 6706 also provides a new section in the Medicare Claims Processing Manual that addresses payment for teaching CRNAs. This section -- Section 140.5 (Payment for Anesthesia Services Furnished by a Teaching CRNA) in Chapter 12 (Physicians/Non-physician Practitioners) is attached to CR 6706.

This new section reiterates that a teaching CRNA (not under the medical direction of a physician) can be paid under Medicare Part B when continuously present and supervising a single case involving a student nurse anesthetist. In this single-case scenario, if the teaching CRNA is supervising a case performed by a student nurse anesthetist and is present with the student throughout the case, payment was made at the regular fee schedule rate. The CRNA should report the service using the usual QZ HCPCS modifier which designates that he or she is not medically directed by an anesthesiologist.

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Further, the American Association of Nurse Anesthetists (AANA) indicates that their standards for approved nurse anesthetist training programs allow a teaching CRNA to supervise two concurrent cases involving student nurse anesthetists. Thus (for services furnished on or after August 1, 2002), a teaching CRNA (not under the medical direction of a physician can also be paid under Medicare Part B when supervising two student nurse anesthetists.

In this scenario, the CRNA has historically been paid in the following manner:

- By recognizing the full base units (assigned to the anesthesia code) when the teaching CRNA is present with the student nurse anesthetist throughout pre and post anesthesia care; and
- By recognizing the actual time the teaching CRNA is personally present with the student nurse anesthetist.

CR 6706 provides that the payment policy for the teaching CRNA in the single student nurse anesthetist case remains unchanged for services furnished on or after January 1, 2010; however, under MIPPA Section 139, when involved with two concurrent cases with student nurse anesthetists (on or after this date), he or she can be paid at the regular fee schedule rate for each case.

To bill the base units for each of the two cases, the teaching CRNA must be present with the student during the pre and post anesthesia care for each case.

In addition, while he or she can decide how to allocate time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status and other factors; the CRNA must continue to devote all of his or her time to the two concurrent student nurse anesthetist cases and not be involved in other anesthesia cases. The teaching CRNA may bill usual anesthesia time for each anesthesia case.

For services furnished on or after January 1, 2010, the teaching CRNA should report these cases with the QZ HCPCS modifier as described above. You should also remember that the teaching CRNA's medical record documentation in these cases must be sufficient to support the payment of the fee and be available for review upon request. Additionally, be aware that no payment is made under Part B for the service provided by a student nurse anesthetist.

Note: No new payment modifiers are being created to describe the services of teaching anesthesiologists or teaching CRNAs. Both teaching anesthesiologists and teaching CRNAs should continue to report their anesthesia services using the existing anesthesia payment modifiers.

Additional Information

You can find more information about payment for teaching anesthesiologists and CRNAs by going to CR 6706, located at http://www.cms.hhs.gov/Transmittals/downloads/R1859CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. You will find updated Medicare Claims Processing Manual

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Chapter 12 (Physicians/Non-physician Practitioners), Sections 50 (Payment for Anesthesiology Services), 100.1.4 (Anesthesia), and 140.5 (Payment for Anesthesia Services Furnished by a Teaching CRNA)) as an attachment to that CR.

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

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New Waived Tests

Provider Types Affected

Clinical diagnostic laboratories billing Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for laboratory tests are impacted by this article.

Provider Action Needed: STOP – Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare Carrier or A/B MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

CAUTION – What You Need to Know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change periodically. CR 6685, from which this article is taken, informs carriers and A/B MACs about the latest new CPT codes that are subject to CLIA edits.

GO – What You Need to Do

Make sure that your billing staff is aware of these CLIA-related changes and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The
CPT codes for the following new tests MUST have the HCPCS modifier QW to be recognized as a waived test.

CPT code/HCPCS modifier	Effective Date	Description
80101QW	March 10, 2009	Amedica Biotech Amedica Drug Screen Test Cup
80101QW	May 11, 2009	Twin Spirit, Inc. DrugSmart Cup
84443QW	June 3, 2009	CLIA waived Inc. Thyroid Test Rapid TSH Cassette {Whole Blood}
86308QW	July 16, 2009	ProAdvantage by NDC Infectious Mononucleosis Test Device (Whole Blood Only)
86318QW	August 7, 2009	Pro-Advantage by NDC H. pylori Device (Whole Blood)
87804QW	August 18, 2009	BinaxNOW Influenza A & B Test, K092223

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Other Key Points of CR6685

- Only tests with the following CPT codes DO NOT require a HCPCS modifier QW to be recognized as a waived test: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651,
- For 2009, the description for the CPT code 84155 was modified from "Protein, total, except by refractometry; serum" to "Protein, total, except by refractometry; serum, plasma or whole blood." Therefore, the CPT codes assigned for the total protein test performed on the following test systems have been changed from CPT code/HCPCS modifier 84157QW to 84155QW,
- Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood},
- Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood},
- Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood},
- Abaxis Piccolo xpress Chemistry Analyzer {Liver Panel Plus} (Whole Blood), and
- Arkay SPOTCHEM EZ Chemistry Analyzer (Spotchem II Basicpanel 2) {Whole Blood}.

As a result, Medicare will permit the use of CPT code/HCPCS modifier 84155QW for claims submitted by facilities with a valid and current CLIA certificate of waiver with dates of service on or after January 1, 2009, but Medicare will deny the use of CPT code/HCPCS modifier 84157QW from such facilities with the dates of service on or after January 1, 2010.

Medicare Carriers and A/B MACs will not search their files to adjust claims affected by this change, but processed prior to the implementation of CR 6685. They will, however, adjust such claims that you bring to their attention.

Additional Information

The official instruction (CR6685) issued to your Medicare Carrier and/or A/B MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1857CP.pdf on the CMS website.

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Positron Emission Tomography (PET) (FDG) for Cervical Cancer

Provider Types Affected

Physicians, hospitals, and other providers who provide F-18 flouro-D-glucose (FDG) Positron Emission Tomography (PET) imaging services should be aware of this article if they bill Medicare carriers, Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries with cervical cancer.

What You Need to Know

CR 6753, from which this article is taken, announces a National Coverage Determination (NCD) regarding F-18 flouro-D-glucose (FDG) Positron Emission Tomography (PET) imaging for cervical cancer.

Specifically, (effective for claims with dates of service on and after November 10, 2009) the Centers for Medicare & Medicaid Services (CMS) ends the coverage with evidence development (CED) requirements for FDG PET for cervical cancer; and will cover only one FDG PET for cervical cancer for staging in beneficiaries with biopsy-proven tumors when the treating physician determines that the study is needed to determine the location and/or extent of the tumor for specific therapeutic purposes related to initial treatment strategy (as outlined in the Medicare National Coverage Determination Manual, Section 220.6.17 (FDG PET for Oncologic Conditions (Various Effective Dates).

Background

CR 6753 announces an NCD regarding FDG PET imaging for cervical cancer (including FDG PET/CT). It provides that, effective November 10, 2009 (as the result of a reconsideration request), CMS:

- Ended CED prospective data collection requirements for the use of FDG PET imaging in the initial staging of cervical cancer related to initial treatment strategy;
- Determined that there is no credible evidence that the results of FDG PET imaging are useful in making the initial diagnoses of cervical cancer; or in improving health outcomes; and
- Announced that FDG PET is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (the Act) and, therefore, CMS non-covers FDG PET imaging for initial diagnosis of cervical cancer related to initial treatment strategy.

As a result, CR 6753 provides that (effective for claims with dates of service on and after November 10, 2009), CMS will cover only one initial FDG PET study for staging in beneficiaries who have biopsy-proven cervical cancer when the treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to initial treatment strategy:

- To determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; or,
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of the tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

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NOTE the exception to this policy: CMS continues to non-cover FDG PET for the initial diagnosis of cervical cancer related to initial treatment strategy.

Billing Changes

Effective for claims with dates of service on or after November 10, 2009, your carrier, FI, or MAC will accept FDG PET oncologic claims that you bill to inform initial treatment strategy; specifically for staging in beneficiaries who have biopsy-proven cervical cancer when the beneficiary's treating physician determines the FDG PET study is needed to determine the location and/or extent of the tumor as specified above. Please note that for these claims, the Q0 HCPCS modifier (investigational clinical service provided in a clinical research study that is in an approved clinical research study) is no longer necessary for FDG PET services for cervical cancer.

In addition, your carrier, FI, or MAC will "return as unprocessable/return to provider" your claims for FDG PET for cervical cancer billed to inform initial treatment if all the following are not present:

- PET or PET/CT Current Procedural Terminology (CPT) code (78608, 78811, 78812, 78813, 78814, 78815, or 78816), AND
- PI HCPCS modifier (PET Tumor initial treatment strategy), AND
- ICD-9 cervical cancer diagnosis code.

Failure to use the correct codes will result in the following messages:

- Claim Adjustment Reason Code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- Remittance Advice Remark Code (RARC) MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.
- RARC M16 - Alert: See our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

You should be aware that while your carrier, FI, or MAC will not search their files for FDG PET oncologic cervical cancer claims for initial treatment strategy, for dates of service November 10, 2009, through January 3, 2010, they will adjust such claims that you bring to their attention.

Additional Information

The official CR 6753 was issued in two transmittals, one announcing the NCD as added to the Medicare NCD Manual and the other transmittal providing the revised Medicare Claims Processing Manual instructions. You can find these transmittals at http://www.cms.hhs.gov/Transmittals/downloads/R109NCD.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R1866CP.pdf on the CMS website.

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

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2010 Annual Update to the Therapy Code List

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare Carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs) for outpatient rehabilitation therapy services should take note of this article.

Provider Action Needed

This article is based on Change Request (CR) 6719, which updates the therapy code list for Calendar Year (CY) 2010 with one "Sometimes Therapy" CPT code 92520 (laryngeal function studies (i.e., aerodynamic testing and acoustic testing)). Note that this code always represents therapy services when performed by therapists and requires the use of a therapy modifier.

Background

The Social Security Act (Section 1834(k)(5); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/Current Procedural Terminology 2010 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services. The additions, changes, and deletions to the therapy code list reflect those made in the Calendar Years (CYs) 2009 and 2010 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

CR 6719 updates the therapy code list by adding one "sometimes therapy" code for CY 2010 shown in the table below. Note that this code always represents therapy services when performed by therapists and requires the use of a therapy modifier.

Therapy CPT Code	Descriptor
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)

In addition, CR 6719 announces that CPT code 95992 (Standard Canalith repositioning procedure(s), (e.g., Epley maneuver, Semont maneuver), per day) is being removed from the therapy code list effective January 1, 2010.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the Medicare Claims Processing Manual, Chapter 5 which is available at http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information

You can also find more information about the therapy code List at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage on the CMS website.

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The official instruction, CR 6719, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1850CP.pdf on the CMS website.

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

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Medical Director's Desk

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
Cardiac Computed Tomography & Angiography (CCTA) 2006-01LR6	Revision Made: 2010 Annual CPT Update; Addition of CPT codes 75571-75574, removal of deleted CPT codes 0145T-0151T.	01/01/2010
Cardiac Radionuclide Imaging 2001-41LR16	Revision Made: 2010 Annual CPT Update; Addition of CPT codes 78451-78454, removed deleted CPT codes 78460-78465, 78478, and 78480.	01/01/2010
Chemodenervation 2001-25LR15	Revision Made: 2010 Annual CPT Update; Addition of HCPCS code J0586.	01/01/2010
Chemotherapy and Biologicals 2002-29LR56	Revision Made: 2010 Annual CPT Update: Addition of HCPCS codes J9155 (Degarelix 1 MG) replaces NOC HCPCS code J9999, J9171 (Docetaxel 1 MG) covered for same ICD-9 codes as deleted HCPCS code J9170, and J9328 (Temozolomide 1 MG) with addition of ICD-9 codes 191.0-191.9 as supporting medical necessity for HCPCS code J9328. Removal of deleted HCPCS codes J9170 and Q2024. Effective 11/01/2009 addition of ICD-9 codes 183.0-183.9, and 188.0-188.9 as supporting medical necessity for HCPCS code J9305 (Pemetrexed; Alimta). The Indications Section was clarified to reference individual consideration for off-label use.	01/01/2010
Percutaneous Transluminal Angioplasty 2001-10LR11	Revision Made: 2010 Annual CPT Update; Addition of CPT codes 36147 and 36148; removed deleted HCPCS codes G0392 and G0393.	01/01/2010
Transthoracic Echocardiography 2001-14LR17	Revision Made: 2010 Annual CPT Update; Addition of HCPCS code J0461, removed deleted HCPCS code J0460.	01/01/2010
Non-Covered Category III CPT Codes 2007-01LR10	Revision Made: 2010 Annual CPT Update; Addition of CPT codes 0203T-0222T, removed deleted CPT codes 0062T-0070T, 0077T, 0086T, 0087T, 0144T, and 0194T.	01/01/2010

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LCD	Change	Effective Date
Paravertebral Facet Joint Block 2000-31LR8	Revision Made: 2010 Annual CPT Update; addition of CPT codes 64490-64495, removed deleted CPT codes 64470-64476. Removed CPT code 77003 from the policy due to a change in the code description.	01/01/2010
Neuromuscular Electrodiagnostic Testing 2001-47LR14	Revision Made: 2010 Annual CPT Update; Addition of CPT code 95905.	01/01/2010
Radiation Oncology 2000-03LR24	Revision Made: 2010 Annual CPT Update; Addition of CPT code 77338.	01/01/2010
Virtual Colonoscopy (CT Colonography) 2006-02LR3	Revision Made: 2010 Annual CPT Update; Addition of CPT codes 74261 and 74262. Removed deleted CPT code 0067T. Replaced deleted CPT code 0066T with CPT code 74263 in the Limitations section.	01/01/2010

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Part B
Palmetto GBA
Redetermination/Reopening Request Form

*** Incidates required field.**

* State/Region: ___HI ___NCAL ___NV ___OH ___SCAL ___WVA ___S Carolina ___RRB

*Patient's Name: ______________________ *Provider Name: ______________________

*Health Insurance Claim (HIC) number: ______________ *Billing Provider Number (PTAN): ______________

*Date of Service: ______________________ *Billing Provider Number (NPI): ______________

*CPT code(s): ______________________ *Tax ID: ______________________

Claim Number (ICN): ______________________ ICD-9 code(s): ______________________

Request is within 120 days of initial determination. ___ Yes ___ No. If no, must include reason.

Reason: ____

____

You must choos one of the following options:

__ This is a 1st Level Appeal (Redetermination) **(Do NOT use this form form for a QIC Reconsideration or if you have received message MA-130 on your Remittance Advice)**

__ This is an appeal of an overpayment (attach copy of overpayment demand letter) FCN/AR#: ______________

__ This is a Reopening (simple claim correction). Go to http://www.PalmettoGBA.com for information on reopenings

__ This is a Medical Review Reopening (i.e., Remark code N102 on Remittance Advice)

__ This is a Recovery Audit Contractor (RAC) overpayment appeal (attach copy of overpayment demand letter)

Reason for Request: ____

____

____

____

Name of Requestor: ______________________

Name: ______________________

Address: ______________________

City: ______________ State: _____ Zip Code: _________

Phone Number: ______________________

____

Requestor Signature Required
(First Initial and Full Last Name)

Date: ______________________

http://www.Palmetto GBA.com

Please mail your request and all supporting documentation to:

State where service performed	Please send form to:	PO Box/City/State/Zip
HI/NCAL/SCAL/NV/Guam/ American Samoa/N. Mariana Is.	Palmetto GBA Part B- J1 MAC	P.O. Box 1252 Augusta, GA 30903-1252
Ohio/West Virginia	Palmetto GBA Part B	P.O. Box 182933 Columbus, OH 43218-2933
South Carolina	Palmetto GBA Part B	P.O. Box 100190 Columbia, SC 29202-3190
Railroad	Palmetto GBA-Railroad	P.O. Box 10066 Augusta, GA 30999

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MEDICARE
Part A Intermediary
Part B Carrier

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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MEDICARE
Part A Intermediary
Part B Carrier

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: ____________________

Contractor Numbers: 00884

Palmetto GBA – West Virginia Medicare Part B Carrier

Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 332-7025
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CMS Web Training

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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