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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2010, Issue 9

www.cms.gov

www.PalmettoGBA.com/Medicare

September 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/Medicare>.

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Provider Contact Center Training/Holiday Closure Schedule for 2010

The Palmetto GBA Part B Provider Contact Center (PCC) will continue to close up to eight hours per month for Customer Service Representative (CSR) training and staff development. Please note, our Interactive Voice Response (IVR) unit will be available during these scheduled training sessions for automated customer service transactions. Listed below are training closure dates and times for 2010:

Date	PCC/Office Closed
August 6, 2010	PCC closed 8:30 a.m. - 12 p.m.
August 20, 2010	PCC closed 8:30 a.m. - 12:30 p.m.
September 2, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
September 6, 2010	Office closed/Labor Day
September 9, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
September 16, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
September 23, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
October 11, 2010	*PCC closed/Columbus Day
October 21, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
October 28, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
November 11, 2010	*PCC closed/Veterans Day
November 25-26, 2010	Office closed/Thanksgiving
December 2, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
December 9, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
December 16, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
December 23-24, 2010	Office closed/Christmas
December 30, 2010	PCC closed 8:30 a.m. - 10:00 a.m.
December 31, 2010	Office closed/New Year's Day (2011)

*Although our company will be open on these days, the PCC will use these federal holidays to conduct training.

Changes to our planned closure schedule will be communicated at least three-weeks in advance via the Web site, IVR features and automatic e-mail notifications.

Our CSRs are available from 8:30 a.m. to 4:30 p.m. (ET), Monday through Friday. You may contact our PCC at (866) 332-7025. The IVR only line is (877) 567-9232.

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Reminder of Physician/Group Practice Name Changes and Collapsed PTANs

AdvanceMed (AM) is the Program Safeguard Contractor (PSC) for Medicare Part B in Kentucky and Ohio and Medicare Part A in Kentucky, Ohio and Minnesota. As the PSC, AdvanceMed is responsible for ensuring Medicare funds are paid appropriately. In order to accomplish this task, AdvanceMed conducts data analysis, audits of medical records and responds to complaints. Many complaints received by the PSC are the result of billing errors and misunderstandings which are easily remedied.

Recently, AdvanceMed received several beneficiary complaints alleging that their Medicare Summary Notices (MSN) were not reflective of the provider that had actually rendered services to them. On investigation by AM (the PSC) in this case, it was determined that the provider had made a practice name change and did not notify the beneficiary community they provide service to. MSNs can be confusing to beneficiaries, especially when an established medical practice changes its name or address as part of consolidating PTANs. Some physicians associated with the PTAN may not be located at the main office branch (which is the address that appears on the MSN), so beneficiaries might suspect that fraud is occurring if they are looking at an address that is different from the office location where they received care.

AdvanceMed encourages the provider community to alert their patients when making such changes in order to avoid an unnecessary audit by the PSC.

For more information, please refer to MLN Matters article MM5906 “Collapsing Medicare Provider Transaction Access Numbers (PTANs) to Ensure a One-to-One National Provider Identifier (NPI) Match” at <http://www.cms.gov/MLNMattersArticles/downloads/MM5906.pdf>.

Medical Record Retention and Media Formats for Medical Records

Provider Types Affected

This is an informational article for physicians, non-physician practitioners, suppliers, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries.

Provider Action Needed: Impact to You

This Special Edition is informational in nature. There are no additions or changes to current policies and procedures.

What You Need to Know

This article provides guidance for physicians, suppliers, and providers on record retention timeframes.

What You Need to Do

Review the information in this article and ensure that you are in compliance. Be sure to inform your staff.

Retention Periods

State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt State laws if they require shorter periods. Your State may require a longer retention period. The HIPAA requirements are available at 45 CFR 164.316(b)(2)

(http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl) on the Internet.

While the HIPAA Privacy Rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. The Privacy Rule is available at 45 CFR 164.530(c)

(http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl) on the Internet.

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report. This requirement is available at 42 CFR 482.24[b][1]

(http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html) on the Internet.

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CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504 [d][2][iii] (<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=ab240bf0e5f6388a75cbe07cc5cf1d21;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr>) on the Internet.

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Providers may want to obtain legal advice concerning record retention after these time periods and medical document format.

Additional Information

CMS is currently engaged in a multi-year project to offer incentives to eligible providers that meaningfully use certified electronic health records (EHRs). In close coordination with this incentive program, the Office of the National Coordinator for Health IT (ONC) has developed the initial set of standards and certification requirements for EHRs in order to promote health information exchange and interoperability. You may be eligible to receive incentive payments to assist in implementing certified EHR technology systems.

Use of “certified EHR technology” is a core requirement for physicians and other providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Additional information about this initiative may be found at <http://www.cms.gov/EHRIncentivePrograms/> on the CMS website.

If you have questions, please contact the Palmetto GBA Provider Contact Center at their toll-free number, (866) 332-7025 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

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Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports

Note: This article was revised on July 23, 2010, to update the “Additional Information” section with current Web addresses. All other information remains the same.

Provider Types Affected

Individual Eligible Professionals (EPs) requesting reports based on their individual National Provider Identifier (NPI) have an alternative means of accessing those reports. Physicians and other practitioners who qualify as individual EPs under the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) and the 2009 E-Prescribing Incentive Program can request feedback reports through their claims processing contractor. The MLN Matters article (MM6394) listing individual EPs under these incentive programs may be found at

<http://www.cms.gov/MLN MattersArticles/downloads/MM6394.pdf> on the CMS website.

What You Need to Know

- CMS has created an alternative process that individual EPs may use to request 2007 Re-Run and 2008 PQRI feedback reports based on their individual NPI.
- Based on the nature of your questions (e.g., status of your PQRI incentive payment, measures, coding, or the feedback reports), you may need to contact different entities.
- E-Prescribing feedback reports for data submitted in calendar year 2009 will be available in late 2010. CMS will notify EPs when they can begin requesting these reports using this alternative process.

You should make sure your billing staffs are aware of this information. Please refer to the information below for more details.

Background

In the past, EPs could only access PQRI feedback reports through a secure website after first registering in the CMS security system known as Individuals Authorized Access to the CMS Computer Services (IACS). CMS is now offering an alternative feedback report request process which will be available beginning October 19, 2009.

This new process eliminates the need for individual EPs to register in IACS for their feedback report.

Alternative PQRI Feedback Report Request Process for Individual EPs

Beginning on October 19, 2009, individual EPs can call their respective carrier or A/B MAC Provider Contact Center to request 2007 Re-Run and 2008 PQRI feedback reports that will contain data based on their individual NPI. This means that EPs who are part of a group practice can get their individual feedback reports as well.

When requesting feedback reports, EPs will be asked to provide an e-mail address. EPs can then expect to receive the e-mailed feedback report within 30 days of the request. If no report is available, the provider will receive an e-mail notification.

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EPs Requesting Reports Based on Taxpayer Identification Number (TIN) for Group Practice Information

EPs who request feedback reports based on TIN or group practice information will still be required to access their PQRI feedback reports via the PQRI Portal after first registering in IACS. An IACS user identification and password is required to access the PQRI Portal. The PQRI Portal may be found at <http://www.qualitynet.org/pqri> on the Internet.

Correct Contact Based on Questions

CMS has provided the following resources to answer your questions about the PQRI and E-Prescribing programs, incentive payments, feedback reports, and IACS registration and account issues.

1. A/B MAC and Carrier Provider Contact Centers can answer questions concerning incentive payment status, such as:
 - Was my incentive payment sent?
 - What is my incentive payment amount?
 - What does my Remittance Advice(s) mean?

To get a list of Provider Contact Centers, see

<http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website.

2. Quality Net Help Desk can provide general PQRI and E-Prescribing information as well as answer questions about PQRI feedback report availability and access, coding, measures, and the feedback reports themselves. Examples of questions they can assist with include:
 - Do I have a PQRI feedback report available for this TIN or NPI?
 - When will my PQRI feedback reports be available?
 - Why am I unable to view my PQRI feedback report on the PQRI Portal?
 - Did I qualify for a PQRI incentive payment?
 - When will my PQRI incentive payment be available?
 - Can you explain a specific part of my PQRI feedback report?

Contact the QualityNet Help Desk Monday – Friday from 7:00 a.m. - 7:00 p.m. CST at 1-866-288-8912 or by email: qnetsupport@sdps.org.

3. External User Services (EUS) can resolve issues concerning IACS registration and account issues such as:
 - I need help registering in IACS;
 - I need help accessing my IACS account;
 - I need help changing my IACS account; and,
 - I need help approving users in my organization.

Contact EUS at 1-866-484-8049 Monday - Friday from 7:00 a.m. - 7:00 p.m. EST or by email:

EUSsupport@cgi.com.

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Additional Information

Please remember that EP and group practice provider enrollment information must be current in the Medicare Provider Enrollment Chain and Ownership System (PECOS) in order to request an IACS account. An IACS account is needed to access the PQRI Portal and view or download TIN-level PQRI feedback reports. See <http://www.cms.gov/MedicareProviderSupEnroll/> for more information, including a link to Internet-based PECOS.

To get a list of Provider Enrollment contact numbers, see http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website. For information about IACS, see <http://www.cms.gov/IACS> on the CMS website.

There are other sources where you can find additional information.

- For PQRI Program information and resources, see <http://www.cms.gov/PQRI> on the CMS website.
- To download a copy of the “2007 Re-Run and 2008 PQRI Feedback Report User Guide”, see <http://www.cms.gov/PQRI/2008/list.asp#TopOfPage> on the CMS website. On the 2008 PQRI Program webpage, check the following option: [X] ‘Show only items whose Type is’. Then select ‘Feedback Reports’ from the drop down list.
- To download a copy of “A Guide for Understanding the 2008 PQRI Incentive Payment”, see <http://www.cms.gov/PQRI/downloads/GuideUnderstanding2008PQRIIncentivePayment072109.pdf> on the CMS website.
- To download a copy of “A Guide for Understanding the 2007 Re-Run PQRI Incentive Payment”, see <http://www.cms.hhs.gov/PQRI/Downloads/GuideforUnderstanding2007Re-RunPQRIIncentivePayment063508.pdf> on the CMS website.
- To access the PQRI Portal and to verify the 2007 Re-Run or 2008 PQRI Feedback Report availability for a TIN or NPI, see <http://www.qualitynet.org/pqri> on the QualityNet website.
- To download the PQRI Portal User Guide, see the “Downloads” section on http://www.cms.gov/PQRI/30_EducationalResources.asp on the CMS website.
- For general E-Prescribing Information, see <http://www.cms.gov/eRxIncentive> on the CMS website.
- For information on the PQRI National Provider Call Schedule and Open Door Forum, see http://www.cms.gov/PQRI/04_CMSSponsoredCalls.asp on the CMS website.
- For 2009 PQRI program information, see <http://www.cms.gov/PQRI/2009/list.asp> on the CMS website.
- For a list of Qualified Registries/Qualified EHR Vendors, see http://www.cms.gov/PQRI/20_alternativereportingmechanisms.asp on the CMS website.

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Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services

Note: This article was revised on July 22, 2010, to include “ambulatory surgical centers” in the last sentence in the top paragraph of page 3. All other information remains the same.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, providers, and imaging centers.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare Intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC).

Provider Action Needed

This Special Edition describes SNF Consolidated Billing (CB) as it relates to certain types of exceptionally intensive outpatient hospital services, such as Magnetic Resonance Imaging (MRI) services, Computerized Axial Tomography (CT) Scans, and Radiation Therapy.

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see MLN Matters Special Edition article SE0431 at <http://www.cms.gov/MLN MattersArticles/downloads/se0431.pdf> on the CMS website.

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

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Moreover, these services were excluded categorically, without regard to the specific setting in which they were furnished. This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, the Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L.106-113, Appendix F).

While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF “resident” for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans. These services include:

- Emergency services;
- Cardiac catheterizations;
- Computerized Axial Tomography (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

CMS established that a beneficiary’s receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the Code of Federal Regulations (42 CFR), Section 411.15(p)(3)(iii).) The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to “...certain outpatient services from a Medicare participating hospital or critical access hospital...” (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641)). This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics or ambulatory surgical centers).

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories

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of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished.

For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS Code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is NOT subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.

Additional Information

See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at

<http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf> on the CMS website.

The Centers for Medicare and Medicaid Services (CMS) MLN Consolidated Billing Website can be found at <http://www.cms.gov/SNFConsolidatedBilling/> on the CMS website.

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.
- The SNF PPS Consolidated Billing Website can be found at <http://www.cms.gov/SNFPPS/> on the CMS website.
- It includes the following relevant information:
 - Background;
 - Historical questions and answers;
 - Links to related articles; and
 - Links to publications (including transmittals and Federal Register notices).

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Timely Claims Filing: Additional Instructions

Provider Types Affected

This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment 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.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7080 to expand the Medicare Fee-for-Service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

Background

CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended length of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the claim's "Through" date rather than the "From" date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the "From" date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claims processing contractors in their determination of timely filed claims. Therefore, the "From" date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the "From" date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key Points of CR 7080:

- For institutional claims that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim will be used to determine the date of service for claims filing timeliness.
- For professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "From" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).
- BE AWARE: If a line item "From" date is not timely, but the "To" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.

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- Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional Information

Remember CR6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-ACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline; and
- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

You can find the official instruction, CR7080, issued to your carrier, FI, A/B MAC, or RHHI by visiting <http://www.cms.gov/Transmittals/downloads/R734OTN.pdf> on the CMS website.

To review MM6960, Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months, you may go to <http://www.cms.gov/MLN MattersArticles/downloads/MM6960.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

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Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home

Provider Types Affected

This article is for physicians and other providers who bill Medicare contractors (carriers and Medicare Administrative Contractors (A/B MAC)) for services provided to Medicare beneficiaries in Place of Service (POS) Home (or any other place of service that Medicare contractors consider to be home).

What You Need to Know

CR 6947, from which this article is taken, represents no change to payment policy. CR 6947 requires that you now enter the address of where services were performed, including the ZIP code, on claims for anesthesia services and every service payable under the Medicare Physician Fee Schedule (MPFS), for services provided in all places of service, including Home. This change will be effective for claims that you submit on the 5010 version of the ANSI X12N 837 P electronic form that are processed by Medicare on or after January 1, 2011, and on the paper Form CMS-1500 with dates of service on or after January 1, 2011. (Claims submitted on the 4010A1 electronic form are not impacted by this change.) You should make sure that your billing staffs are aware of this change.

Background

Currently, you are required to submit claims for anesthesia services and for services payable under the MPFS with the address and Zip code of where the service was performed included on the claim for services provided in all places of service (POS), except when the POS is home. In order to stay consistent with the 5010 version of the ANSI X12 N 837 P format (which is to become effective on January 1, 2011) the exception for POS home will no longer be effective.

Specifically, CR 6947 from which this article is taken, announces that effective for claims that you submit using the 5010 version of the ANSI X12N 827 P electronic claim form that are processed on or after January 1, 2011, and for paper claims that you submit on the Form CMS-1500 with dates of service on or after January 1, 2011; you will need to submit the address and 5 digit ZIP code (or the 9-digit code when required per the CMS ZIP Code file) of where the service was provided for services performed in all places of service, including POS home - 12, (and any other POS that contractors at their discretion consider to be home). Your carrier or A/B MAC will use that ZIP code to determine the correct payment locality.

Additionally, please remember that you cannot submit the Form CMS-1500 with more than one POS. Separate CMS-1500 claims must be submitted for each POS. Your carrier or A/B MAC will return as unprocessable such claims if you include more than one POS.

When returning these claims with more than one POS, Medicare contractors will use the following Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs):

- CARC 16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

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- RARC M77 - Missing/incomplete/invalid place of service.
- RARC MA130 - Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

When returning claims for failing to include the address where the service was performed, Medicare contractors will use the following CARC and RARCs:

- CARC 16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- RARC MA114 - Missing/incomplete/invalid information on where the services were furnished.
- RARC MA130 - Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note that claims submitted on the 4010A1 version of the electronic claim form are not affected by CR 6947.

Additional Information

You can find the official instruction, CR, 6947, issued to your carrier or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2015CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

You will find the revised Medicare Claims Processing Manual Chapter 1 (General Billing Requirements), Sections 10.1.1 (Payment Jurisdiction Among Contractors for Services Paid Under the Physician Fee Schedule and Anesthesia Services), 10.1.1.1 (Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004), and 80.3.2.1.2 (Conditional Data Element Requirements for Carriers and DMERCs) as an attachment to that CR.

If you have questions, please contact the Palmetto GBA Provider Contact Center at their toll-free number, (866) 332-7025 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

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Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted or Terminated

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

What You Need to Know

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

- 1) Reopen certain MSP claims when certain MSP records are deleted, or
- 2) Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare Secondary Payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

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Additional Information

You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2014CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

If you have questions, please contact the Palmetto GBA Provider Contact Center at their toll-free number, (866) 332-7025 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

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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 7089, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2010 for Medicare. These are the changes that have been added since CR 6901. 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 some 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.

The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee, and used by all payers. This committee meets 3 times a year, and this code list also gets updated 3 times a year – in 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 7089.

Additional Information

To see the official instruction (CR7089) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to <http://www.cms.gov/Transmittals/downloads/R2019CP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
235	Sales Tax	6/6/2010

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Modified Codes – CARC: None

Deactivated Codes – CARC: None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan	NO
N534	This is an individual policy, the employer does not participate in plan sponsorship	NO
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service	YES
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us	NO
N537	We have examined claims history and no records of the services have been found	NO
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents	NO
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied	NO

Modified Codes – RARC

Code	Modified Narrative	Medicare Initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov	YES

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Code	Modified Narrative	Medicare Initiated
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LCD	YES
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp . If you do not have web access, you may contact the contractor to request a copy of the NCD.	YES
N528	Patient is entitled to benefits for Institutional Services only	NO
N529	Patient is entitled to benefits for Professional Services only	NO
N530	Not Qualified for Recovery based on enrollment information	NO

Deactivated Codes – RARC

Code	Current Narrative	Note
M118	Letter to follow containing further information	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service	Consider using N130

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October Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed

This article is based on CR 7070, which provides the required quarterly update of the 2010 DMEPOS Fee Schedule. Be sure billing staffs are aware of the update.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the Medicare Claims Processing Manual, Chapter 23, and Section 60 at

<https://www.cms.gov/manuals/downloads/clm104c23.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key Points of CR7070

- Per Transmittal 686 (Change Request 6743), the claims filing jurisdiction for HCPCS code L8509 (Tracheo-Esophageal Voice Prosthesis, Inserted by a Licensed Health Care Provider, Any Type) is changing from the DME MACs to the A/B MACs/Part B carriers, effective October 1, 2010. To reflect this change, the claims jurisdiction for HCPCS code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.
- As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors will adjust previously processed claims for HCPCS code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments.

Additional Information

The official instruction, CR 7070, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2006CP.pdf> on the CMS website.

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An earlier MLN Matters® article, MM6743 on the Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prosthesis Healthcare Common Procedure Coding System (HCPCS) Code may be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/MM6743.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

HCPCS Code	State	Fee Schedule Amount	Effective Date
L8509	Ohio	\$99.08	10/1/2010
L8509	West Virginia	\$96.71	10/1/2010

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Maximum Allowed Units Update: August 20, 2010

The following has been added to the MAU table:

HCPCS Code	Description	MAU	Change
J2278	Injection, ziconotide, 1 mcg	500	Added

Special Instructions:

Palmetto GBA considers compounding ziconotide with morphine sulfate as investigational and will NOT reimburse HCPCS code J2278 in this combination.

Ohio and West Virginia Provider Education Listserv

The Palmetto GBA listserv is a wonderful communication tool that offers its members the opportunity to stay informed about:

- Medicare incentive programs
- New legislation concerning Medicare
- Fee Schedule changes
- LCD/NCD changes
- And so much more!

What is needed to receive updates?

- Internet access and an e-mail address
- 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	
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 Facility	Psychology/Psychiatry
	Community Mental Health Center	Nephrology	Radiology
	Diagnostic Tests	Non-Physician Practitioners	Surgery
	Drugs/Biologicals	Ophthalmology/Optometry	
	Electronic Data Interchange (EDI)	Pathology & Laboratory	

Palmetto GBA

August 2010

A CMS Contracted Intermediary and Carrier

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Revisions and Re-issuance of Audiology Policies

Note: This article was revised on July 26, 2010, to include revised effective and implementation dates, a revised CR release date, transmittal numbers, and Web addresses for accessing the transmittals. In addition, Claim Adjustment Reason Codes and Remittance Advice Remark Codes have been added, where appropriate. The Web address for accessing the Audiology code list was also revised. All other information is the same.

Provider Types Affected

This article is for physicians, non-physician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare Administrative Contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6447. The Centers for Medicare & Medicaid Services (CMS) issued CR 6447 to respond to provider requests for clarification of some of the language in CR5717 and CR6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare Physician Fee Schedule (MPFS). See the Key Points section below for the clarifications provided by CR6447.

Background

Key parts of the clarified policy are in the revised Chapter 12, Section 30.3 of the Medicare Claims Processing Manual and in Chapter 15, Section 80.3 of the Medicare Benefit Policy Manual. These revised manual sections are attached to CR 6447. As mentioned in these revised sections of the manuals and per Section 1861 (ll) (3) of the Social Security Act, “audiology services” are defined as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician. These hearing and balance assessment services are termed “audiology services,” regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

Note: References to technicians in CR 6447 and this article apply also to other qualified clinical staff. The qualifications for technicians vary locally and may also depend on the type of test, the patient, and the level of participation of the physician who is directly supervising the test. Therefore, an individual must meet

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qualifications appropriate to the service furnished as determined by the Medicare contractor to whom the claim is billed. If it is necessary to determine whether the individual who furnished the labor for appropriate audiology services is qualified, contractors may request verification of any relevant education and training that has been completed by the technician, which shall be available in the records of the clinic or facility.

Audiology services, like all other services, should be reported under the most specific HCPCS code that describes the service that was furnished and in accordance with all CPT guidance and Medicare national and local contractor instructions.

See the CMS website at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp for a listing of all CPT codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at <http://www.cms.gov/PFSlookup/> allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

Qualifications Discussion

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test;

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- Development and modification of the test battery and test protocols;
- Clinical judgment, assessment, evaluation, and decision-making;
- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes;
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contralateral masking; and/or
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss

Key Points of CR 6447

- For claims with dates of service on or after October 1, 2008 audiologists are required to be enrolled in the Medicare program and use their National Provider Identifier (NPI) on all claims for services they render in office settings.
- For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital Outpatient Prospective Payment System (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.
- Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services as shown in Chapter 15, Section 80.3 of the Medicare Benefit Policy manual as attached to CR 6447.
- For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician. In denying such claims, Medicare will use:
- CARC 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
 - o Remittance Advice Remark Code (RARC) MA102 (Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.)
- Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician

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under the direct supervision of a physician if the test requires professional skills. Such claims will be denied using Claim Adjustment Reason Code (CARC) 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.).

- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
 - o CARC 185 (The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
 - o RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.)
- Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service. (Once again, the list of audiology services is posted at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp on the CMS website.)
- Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp and are not "always" therapy services and the audiologist is qualified to perform the service.
- All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
- When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the

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technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.

- The “global” service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- The opt out law does not define “physician” or “practitioner” to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

Additional Information

There are two transmittals related to CR6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the Medicare Benefit Policy Manual and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R129BP.pdf> on the CMS website. The other transmittal modifies the Medicare Claims Processing Manual and it is at <http://www.cms.gov/Transmittals/downloads/R2007CP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

Roster Billing Guide for Influenza and Pneumonia Immunizations to Medicare Part B

Roster billing is a simplified process used by mass immunizers. Palmetto GBA has prepared a packet for health care providers who mass immunize their patients against influenza and pneumonia. The packet contains instructions on how to submit claims using the roster billing method. Please share this information with appropriate members of your staff.

A **PC-ACE Pro32 Software User's Manual** has been created to provide you with information on Medicare's courtesy software, PC-ACE Pro32, which allows for electronic roster billing. Medicare provides the software and technical support free of charge.

A copy of this packet can be found at:

State	Web Site
Ohio Part B	http://www.PalmettoGBA.com/boh/forms
South Carolina Part B	http://www.PalmettoGBA.com/bsc/forms
West Virginia Part B	http://www.PalmettoGBA.com/bwv/forms

If you have questions regarding influenza and pneumonia immunizations contact the appropriate Medicare Part B Provider Contact Center that processes your claims:

State	Toll-Free Telephone Number
Ohio & West Virginia Part B	(866) 332-7025 Monday-Friday, 8:30 a.m. until 4:30 p.m. (ET)
South Carolina Part B	(888) 828-2092 Monday-Friday, 8:30 a.m. until 4:30 p.m. (ET)

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

Note: This article was revised on August 4, 2010, to reflect the revised CR 7006, which was revised on August 4. In this article, the CR release date and Transmittal number (see above) were changed and the Web address for accessing CR 7006 was also changed. All other information is the same.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Background

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

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

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

Additional Information

For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at <http://www.cms.gov/Transmittals/downloads/R2017CP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

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Definition of Ambulance Services

Provider Types Affected

This article applies to ambulance suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for ambulance services provided to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7058 which updates the Medicare Benefit Policy Manual (Chapter 10, Section 30.1.1) to incorporate the application of Basic Life Support (BLS) – Emergency; Advanced Life Support Level 1 (ALS1) and Emergency and Advanced Life Support Level 2 (ALS2) information. No new policy is presented but the CR7058 updates the relevant manual section to reflect current policy. The updated manual section is attached to Cr 7058.

Background

CMS issued MM7058 to update the relevant manual sections and provides the following application-based examples to accompany the definitions of BLS, ALS1 and ALS2 as follows:

Basic Life Support (BLS) Emergency

Application: The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced Life Support, Level 1 (ALS1) - Emergency

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advance Life Support, Level 2 (ALS2)

Application: Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous

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injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3rd of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol, calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, in order to receive payment for an ALS2 level of service based in part on the administration of Epinephrine, three separate administrations of Epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

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Additional Information

The official instruction associated with this CR7058, issued to your Medicare A/B MAC, carrier and/or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R130BP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs

Provider Types Affected

This article is for physicians and other providers submitting claims to Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MAC)) for services on the Ambulatory Surgical Centers (ASC) Fee Schedule (ASCFS).

What You Need to Know

This article is based on Change Request (CR) 7078, which clarifies a requirement originally created in CR 5680 to ensure consistency among Medicare contractors. CR 7078 directs Medicare contractors:

- To deny the technical component for all ancillary services on the ASCFS list billed by specialties other than ASCs and where such services are provided in an ASC setting; and
- To deny globally billed ancillary services on the ASCFS list billed by specialties other than ASCs provided in an ASC setting.

The professional component is the only payment allowed for ancillary codes billed by physicians and must be billed separately.

Background

CR 7078 clarifies a requirement originally created in CR 5680, which is addressed in the MLN Matters® article available at <http://www.cms.gov/MLN MattersArticles/downloads/MM5680.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. The CR is intended to ensure consistency among all Medicare contractors. CR 7078 informs those contractors to deny the technical component for all ancillary services appearing on the ASCFS when billed by specialties other than ASCs (specialty 49) when place of service (POS) is ASC (POS = 24). Since the technical component is also included in the global fee, the global payment must also be denied. The professional component is the only payment paid for ancillary codes billed by specialties other than ASCs when POS is the ASC.

When denying the technical component for all ancillary services on the ASCFS list billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare contractors will use the following messages:

- Claim Adjustment Reason Code 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 Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code 97 - Not paid to practitioner when provided to patient in this place of service. Payment included in reimbursement issued the facility.
- Remittance Advice Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

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When denying globally billed ancillary services on the ASCFS list if billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare will use the following messages:

- Remittance Advice Remark Code N200 - The professional component must be billed separately
- Claim Adjustment Reason Code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Note Refer to the 835 healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Additional Information

The official instruction, CR 7078, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2020CP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

Implantable Cardiovascular Monitor (ICM) or Implantable Loop Recorder (ILR) Systems: Clarification of Billing Instructions

Current Procedural Terminology (CPT) code 93299 is the technical component of CPT code 93297 (for an Implantable Cardiovascular Monitor [ICM] system) or 93298 (for an Implantable Loop Recorder [ILR] system). This service involves cardiovascular data or interrogated ECG data transmitted to a monitoring center (an Independent Diagnostic Testing Facility [IDTF]) and reviewed by an electrodiagnostic technician (a certified cardiographic technician employed by the IDTF). The data is then transmitted to the physician for review.

The CPT code 93299 is only reimbursable to the IDTF that is gathering and transmitting the data to the physician. The CPT code 93299 may not be submitted by the physician when an employee of the physician retrieves and reviews the data received from the IDTF. This is effective for dates of service January 1, 2009 and after.

When a technician (who is employed by the physician) retrieves and reviews data from a secure server via modem, the service is included in the reimbursement for CPT code 93297 (ICM) or 93298 (ILR). The CPT codes 93297 and 93298 are for the analysis of recorded data, the physician analysis, and review of reports (the professional component).

In order for the IDTF to receive reimbursement for CPT code 93299, they must have the code added to their provider enrollment file. The addition of this code would require a site visit.

Caution: The CPT code 93299 is only for the monitoring of the aforementioned **Implanted** systems. External systems utilizing hand held devices, belts, wrist straps, and devices connected by external electrodes would not qualify for this code.

Reference:

- The development and coverage guidelines for this service are based on a review of pertinent medical literature and discussions with appropriate specialists
- Current Procedural Terminology CPT 2010, Implantable and Wearable Cardiac Device Evaluations (CPT codes 93279 - 93299), and Cardiography (CPT codes 93000 - 93278).
- Current Procedural Terminology CPT 2009, Changes 'An Insider's View,' available at <http://www.ama-assn.org/>

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Common Working File (CWF) Override Edit for Kidney Transplant Donor Claims When the Kidney Recipient is Deceased

Note: This article was revised on August 6, 2010, to reflect a revised CR 6978, which was re-issued on August 5, 2010. The article was revised to include Regional Home Health Intermediaries (RHHIs) in the Section listing provider types affected. All other information is the same.

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare carriers, fiscal intermediaries (FIs), RHHIs, or Part A/B Medicare Administrative Contractors (A/B MACs) for live kidney donor and related services for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6978 which instructs Medicare contractors to override certain edits on claims for donor expenses when the kidney recipient is deceased. Please make sure your billing staff is aware of these changes.

Background

Medicare instructions allow donor expenses incurred after the death of the kidney recipient to be treated as incurred before the death of the kidney recipient. However, some of these claims are being rejected by Medicare systems. CR6978 corrects this problem for services performed on or after January 1, 2011.

Key Points of CR 6978:

- All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number). Modifier Q3 (Live Kidney Donor and Related Services) must appear on the claim.
- For institutional claims which do not require modifiers, Medicare contractors may process the claim when the donor is receiving institutional services related to the donation of the kidney where the transplant recipient has died and the donor receives those services subsequent to the recipient's death.

Additional Information

The official instruction (CR6978) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.gov/Transmittals/downloads/R2008CP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

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Oral Anticancer Drugs: Coverage Issue

Claims for selected oral anticancer drugs (busulfan, capecitabine, cyclophosphamide, etoposide, fludarabine, melphalan, methotrexate, temozolomide, and topotecan) are eligible for coverage by Medicare Part B and are processed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

In March 2010, the DME MACs published a revised Oral Anticancer Drugs policy which identified the ICD-9 diagnosis codes for which each drug would be covered. The DME MAC policy was revised to be consistent with Medicare's national coverage policy for Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen. That policy is found in the Medicare Benefit Policy Manual, Publication # 100-02, Chapter 15, Section 50.4.5. The revised DME MAC policy was effective for claims with dates of service on or after June 1, 2010.

Recently, the DME MAC medical directors have become aware that the policy revision failed to include a number of diagnoses that are listed in one of the four compendia defined in the Medicare Benefit Policy Manual. A revision of the DME MAC policy with a significantly expanded list of diagnoses is planned for release on August 12. Coverage for all of the added diagnoses will be retroactive to June 1.

Physicians are encouraged to work with pharmacies to assure that their patients continue to receive the chemotherapy drugs that they have ordered.

New Physician Specialty Code for Geriatric Psychiatry

Note: This article was revised on July 20, 2010, to reflect the revised CR 6533, which was issued by the Centers for Medicare & Medicaid Services on July 19, 2010. In this article, the CR release date, transmittal number, and the Web address for accessing CR 6533 were revised. All other information remains the same.

Provider Types Affected

This article is for physicians and non-physician practitioners who bill Medicare carriers and Medicare Administrative Contractors (A/B MAC) for providing psychiatric care to geriatric Medicare beneficiaries.

What You Need to Know

Effective April 1, 2010, the Centers for Medicare & Medicaid Services (CMS) will establish a new physician specialty code (code 27) for Geriatric Psychiatry. In addition, the codes 32, 74, and 75 are being removed from the physician specialty section of the Medicare Claims Processing Manual, because they are non-physician specialty codes. You should ensure that your billing staffs are aware of this new specialty code.

Background

When enrolling in Medicare, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain and Ownership System; and non-physician practitioners are assigned a Medicare specialty code. This specialty code becomes associated with the claims that the physician or non-physician practitioner submits, and describes the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Moreover, CMS uses these specialty codes for programmatic and claims processing purposes.

CR 6533, from which this article is taken, announces that effective April 1, 2010, CMS will establish a new physician specialty code for Geriatric Psychiatry. For care you provide on or after that effective date, your carrier or A/B MAC will recognize and use specialty code 27 as a valid primary and/or secondary specialty code for Geriatric Psychiatry services provided by both individuals and organizations.

Additional Information

You can find more information about the new physician specialty code for geriatric psychiatry services by going to CR 6533, located at <http://www.cms.gov/Transmittals/downloads/R2003CP.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

Payment for Implantable Tissue Markers (Healthcare Common Procedure Coding System (HCPCS) Code A4648) and Implantable Radiation Dosimeters (HCPCS Code A4650)

Note: This article was revised on August 18, 2010, to correct an error in the “What You Need to Know” section on page 1. The HCPCS code of A450 was corrected to show A4650. All other information remains the same.

Provider Types Affected

This article is for physicians who bill Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MAC) for providing services for implantable tissue markers or implantable radiation dosimeters to Medicare beneficiaries.

What You Need to Know

CR 6968, from which this article is taken, clarifies that the Healthcare Common Procedure Coding System (HCPCS) codes for implantable tissue markers (HCPCS A4648 – Tissue marker, implantable, any type, each) and for implantable radiation dosimeters (HCPCS code A6450 -- Implantable radiation dosimeter each) are separately billable, and payable, for physicians when used with Current Procedural Terminology (CPT) codes 19499, 32553, 49411, and 55876.

See the Background section, below, for details. You should make sure that your billing staffs are aware of this coding requirement.

Background

Under the Medicare hospital outpatient prospective payment system (OPPS) and the ambulatory surgical center (ASC) payment system, carriers and A/B MACS do not pay hospitals or ASCs separately for HCPCS codes A4648 (Tissue marker, implantable, any type, each) or A4650 (Implantable radiation dosimeter each); rather, payment for these codes is packaged into the payment for the service in which they are used. Similarly, under the Medicare inpatient prospective payment system (IPPS), payment for these services is bundled into the MS-DRG payment.

NOTE: Hospitals that are not paid under the OPPS or IPPS are paid for HCPCS code A4648 and HCPCS code A4650 under a variety of other payment mechanisms.

CR 6968, from which this article is taken, clarifies that these two HCPCS codes, however, are separately billable and payable, when billed by physicians and when used with one of the following four CPT codes:

1. CPT code 19499 (unlisted procedure, breast);
2. CPT code 32553 (placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter)), percutaneous intra-thoracic, single or multiple);

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3. CPT code 49411 (placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple); and
4. CPT code 55876 (single or multiple((the placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter)), prostate (via needle, any approach)) on a claim for physician services.

Therefore, effective for dates of service on or after November 6, 2010, your carrier or A/B MAC will pay physicians for these HCPCS codes when the implantable tissue markers or implantable radiation dosimeters are used in conjunction with one of these four CPT codes, but will deny payment if one of the above CPT codes is not paid on the same claim (or in history) with the same date of service.

When denying your claim for these codes if the qualifying service is not reported on the same date of service, they will use Claim Adjustment Reason Code B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.).

Please note that CR 6968 makes no changes in current payment policies for HCPCS code A4648 or HCPCS code A4650 for inpatient or outpatient hospital services, or to ASCs.

Additional Information

You can find the official instruction, CR6968, issued to your carrier or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R745OTN.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 (Ohio and West Virginia) or (888) 828-2092 (South Carolina Part B).

Responding to a Request for Therapy Records

This enclosed list is provided as a reminder of what to include when responding to an request:

1. Itemized list of medications, supplies, and services rendered for the billing period.
2. Physician's orders for ALL services billed.
3. Documentation for ALL services billed.
4. Any documentation that will substantiate medical necessity of the services provided to the beneficiary.
5. Please submit the following documentation to support any therapy services ordered, rendered and billed during this episode of care:
 - a) Physician/Non Physician Practitioner (NPP) order/referral for therapy services
 - b) Initial therapy evaluation and any subsequent re-evaluations
 - c) Therapy plans of care/treatment and treatment plan reviews
 - d) Physician/NPP certification/recertifications
 - e) Therapy progress/treatment notes
 - f) Therapy visit notes and treatment logs with minutes documented for each CPT/HCPCS code billed each day of this claim
 - g) All physician/NPP/therapist documentation that supports the medical necessity of the therapy services ordered, rendered and billed
 - h) Itemized list of charges
7. Please send a manifest with medical records submitted and send the medical records in secure packaging to ensure the security of medical records.
8. If responding to multiple requests in a single envelope, ensure each response is clearly separated. If responding to more than one date of service on the same beneficiary, send a response for each request separately. Include a manifest or list identifying each ADR response sent.
9. Attach a copy of the request to each individual claim.
10. Use one staple or elastic band per record to attach the documentation and request together. DO NOT use paper clips as they can become dislodged.
11. Do not punch holes in medical records, as this may obscure valuable information.
12. Return the medical records to the address listed below or on the ADR

Palmetto GBA
P.O. Box 182933
Columbus, OH 43218-2933

13. Do not include any correspondence other than the response to the medical review department in your envelope.
14. Unfortunately, we are not able to accept packages on a C.O.D. basis. Please make sure that you have sent packages with the shipping prepaid.

A checklist, to include with your response, is on the next page.

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Responding to a Request for Therapy Records: Checklist

This list is a reminder of what to include when responding to a request for therapy records:

- D Itemized list of medications, supplies, and services rendered for the billing period.
- D Physician's orders for ALL services billed.
- D Documentation for ALL services billed.
- D Any documentation that will substantiate medical necessity of the services

Please submit the following documentation to support any therapy services ordered, rendered and billed during this episode of care:

- D Physician/Non Physician Practitioner (NPP) order/referral for therapy services
- D Initial therapy evaluation and any subsequent re-evaluations
- D Therapy plans of care/treatment and treatment plan reviews
- D Physician/NPP certification/recertifications
- D Therapy progress/treatment notes
- D Therapy visit notes and treatment logs with minutes documented for each CPT/HCPCS code billed each day of this claim
- D All physician/NPP/therapist documentation that supports the medical necessity of the therapy services ordered, rendered and billed
- D Itemized list of charges

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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.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.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
Debridement of Ulcers and Wounds 2005-06LR4	Revision Made: Addition of ICD-9 code 996.62 as supporting medical necessity for CPT codes 11040-11044, 97597, and 97598.	08/01/2010
Vertebroplasty/Vertebral Augmentation (FKA Kyphoplasty) 2000-36LR9	Revision Made: LCD title & text changed to replace the proprietary term “kyphoplasty” with vertebral augmentation.	09/01/2010
Chemodenervation 2001-25LR16	Revision Made: Addition of HCPCS J3590 (unclassified biologics) for incobotulinumtoxinA; Xeomin, FDA approval date 08/02/2010. Covered for same indications as all botulinium toxins listed in policy.	09/01/2010
Chemotherapy and Biologicals 2002-29LR64	Revision Made: Addition of ICD-9 codes 362.36 and 362.83 as supporting medical necessity for HCPCS code J2778 Ranibizumab; Lucentis.	09/01/2010



**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 choose one of the following options:

- ___ This is a 1st Level Appeal (Redetermination) (**Do NOT use this 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: _____ Requestor Signature Required
(First Initial and Full Last Name)

Address: _____

City: _____ State: _____ Zip Code: _____ Date: _____

Phone Number: _____ <http://www.PalmettoGBA.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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Reconsideration Request Form - QIC North (Ohio)

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

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

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

Contractor Number: 00883

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

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Reconsideration Request Form - QIC South (West Virginia)

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

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

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

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: (866) 332-7025
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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

<http://www.cms.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/medicare>

Important Sources For You

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

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

Attention: Billing Manager