Medicare advisory

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2007, Issue 4 *www.cms.hhs.gov* *www.PalmettoGBA.com* *April 2007*

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You Are Responsible. . .

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

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our Web site at: http://www.PalmettoGBA.com.

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Paper Claims: Reporting Up To 8 ICD-9-CM Codes

Effective for claims processed July 1, 2007, and after, up to eight ICD-9-CM codes may be submitted on Medicare claims. Historically, Medicare used only the first four ICD-9-CM codes when processing claims and has used a manual process to consider the remaining ICD-9-CM codes in the payment determinations. This change will allow Palmetto GBA to process claims using all ICD-9-CM codes reported on the claim (up to eight). Although up to eight ICD-9-CM codes may be reported, you need only submit the number of ICD-9-CM codes necessary to support the service that was rendered. In order for Palmetto GBA to correctly process claims submitted with more than four ICD-9-CM codes, please submit paper claims as follows:

Providers and suppliers must place **two ICD-9-CM codes in each of the fields** (1-4) in item 21 of the CMS-1500 claim form when **more than four** ICD-9-CM codes are submitted. These two ICD-9-CM codes must be **separated by a space, comma, or dash in order for us to validate the submitted ICD-9-CM codes.**

If the ICD-9-CM codes are not submitted as indicated, your paper claim may be delayed or processed without having all submitted ICD-9-CM codes considered.

For additional information, refer to CMS *MLN Matters* article MM 5441: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5441.pdf.

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Medicare Beneficiaries in State or Local Custody Under a Penal Authority

The Centers for Medicare & Medicaid Services (CMS) will deny claims for beneficiaries who are in custody of a State or local government under the authority of a penal statute at the time the provider rendered the service. This provision was implemented in Regulations 42 CFR 411.4(a) and 411.4(b) respectively.

Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, same vigor, as it pursues other debts.

- CMS presumes that a State or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

Regulation 42 CFR 411.4(b) states, "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
2. State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Providers and suppliers who render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) must indicate this fact by using HCPCS modifier "QJ."

- Definition of HCPCS modifier QJ: "Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)."

- This modifier indicates that the provider has been instructed by the State or local government agency that requested the healthcare items or services provided to the patient that it is the policy of the State or local government that the prisoner/patient is responsible to repay the cost of Medical services, and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

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Important:

- HCPCS modifier "QJ" must be entered in the first or second modifier field of Item 24D of the CMS-1500 claim form and in the appropriate field for electronic claims.

- Incarcerated dates of service should not be combined with non-incarcerated dates of service on the same claim.

- Social Security Administration (SSA) provides dates of incarceration to this carrier. The patient must contact his/her local Social Security office prior to requesting an appeal if the incorrect date is on file. Only Social Security can make this correction.

Example: Carrier's record indicates the patient was incarcerated on January 15, 2007, but he/she was actually released January 10th. The Social Security office must correct their records before a claim can be processed correctly.

Appeal rights are given on claims denied in whole or part under this policy upon the initial receipt of the determination of the claim on the basis that on the date of service:

- The conditions of 42 CFR 411.4(b) were met.
- The prisoner/patient was not, in fact, in the custody of a State or local government under authority of a penal statute.

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Modifier Lookup & Claim Resource Lookup: New Web Tools

Modifier Lookup

There is now a great feature on the Palmetto GBA Ohio and West Virginia Web sites. You can now access specific guidance on documentation requirements and submission guidelines for all HCPCS and CPT modifiers! We are very excited to bring you this enhancement and hope that you will find it useful.

To access guidance specific to each modifier, go to the Articles section of our Web site, then select Modifier Lookup. The shortcuts to access the Articles section are:

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

Claim Resource Lookup

A new Web tool, the Claim Resource Lookup, is now available to save your office time and money. This new tool can save time and money for your office since it offers education on the top claim denials and rejects.

What is it?

- A new way of displaying resources for the most common questions and claim problems! The information is categorized by topic. It integrates all of the resources we have available for the top problem and question categories and packages them in a way that is easy to use (and they're in alphabetical order).
- Searching for resources will be much easier with this new format. For example, if you're receiving "medical necessity" denials for trigger point injections, searching from the Ohio or West Virginia home page for "trigger point" will return this as one of the top results. We'll continue to add to this resource list as we find new issues or problems.

Where can you find it?

- From the Ohio or West Virginia home page, select Claim Resource Lookup from the "Topics" or "Resources" section:
  - Ohio: http://www.PalmettoGBA.com/boh
  - West Virginia: http://www.PalmettoGBA.com/bwv

Where did the content come from?

- Our entire Provider Outreach & Education program is centered around data. This includes your feedback, input from our internal departments, CERT errors, data from submitted claims, and questions we receive (telephone and written). It's a very interesting exercise to map data findings to education- this is a terrific way for us to stay focused.

If you have specific suggestions regarding the content of the modifier lookup guidance or claim resource, we'd love to hear from you! We anticipate that we will continue to refine the content based on your suggestions. You are welcome to send content suggestions related to this topic or others through the "How Are We Doing?" link on the home pages of the Ohio and West Virginia Web sites.

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every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80% satisfactorily reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

As detailed instructions, education, and tools to support successful claims-based reporting become available, they will be posted on the CMS PQRI Web site at http://www.cms.hhs.gov/PQRI.

Payment for Reporting

Participating eligible professionals who successfully report as prescribed by TRHCA section 101 may earn a 1.5% bonus, subject to cap. The potential 1.5% bonus will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007, (2) received into the CMS National Claims History (NCH) file by February 29, 2008, and (3) paid under the Medicare Physician Fee Schedule. Because claims processing times may vary by time of the year and Medicare Carrier/Medicare Administrative Contractor (MAC), participating eligible professionals should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008. There is no beneficiary copayment or notice to the beneficiary regarding the bonus payments.

The bonus will apply to allowed charges for all covered professional services, not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the physician fee schedule amounts for assigned and non-assigned claims will not apply to the bonus. The statute defines PQRI covered services as those paid under the Physician Fee Schedule only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology. Other Part B services and items that may be billed by eligible professionals but are not paid under the Physician Fee Schedule, such as clinical laboratory services, pharmaceuticals billed by physicians, and Rural Health Center/Federally Qualified Health Center services, do not apply to the bonus.

A payment cap that would reduce the potential bonus below 1.5% of allowed charges may apply in situations where an eligible professional reports relatively few instances of quality measure data. Eligible professionals' caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80% threshold), by (2) a constant of 300%, and by (3) the national average per measure payment amount.

The national average per measure payment amount is one value for all measures and all participants that is calculated by dividing: (1) the total amount of allowed charges under the Physician Fee Schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program by (2) the total number of instances for which data were reported by all participants in the program for all measures during the reporting period. (Note that the national average per measure payment amount calculation only takes into account the charges on claims

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for which quality measures were reported, whereas the individual bonus calculation takes into account charges for all services furnished during the reporting period.) Thus, while the purpose of the cap is clear, it is not possible to determine the impact of the cap until the national average per measure payment amount can be calculated after the end of the reporting period.

TRHCA section 101 specifies that for 2007, CMS must use the Taxpayer Identification Number (TIN) as the billing unit, so any bonuses earned will be paid to the TIN holder of record. Though the analysis of satisfactory reporting will be performed at the individual eligible professional level using individual-level NPI data (as discussed above in the Form and Manner of Reporting section), bonuses will paid to the holder of the TIN, aggregating individual bonuses for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS plans to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the bonus payment under more than one TIN will receive a separate bonus payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, the statute specifies that any bonus payment earned will be paid to the employers or facilities.

Validation

TRHCA section 101 requires CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. CMS plans to focus on situations where eligible professionals have successfully reported fewer than three quality measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the bonus incentive payment.

Appeals

The statute specifically states that there shall be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, (3) the payment limitation or cap, or (4) the bonus incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

Confidential Feedback Reports

CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum bonus payments are made in mid-2008. There will be no interim feedback during 2007. Quality data reported under the 2007 PQRI will not be publicly reported.

Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2007 PQRI or to receive a bonus payment.

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Transition from the 2006 Physician Voluntary Reporting Program (PVRP)

The 2007 PQRI will build on and replace the 2006 Physician Voluntary Reporting Program (PVRP), which was implemented as the first step toward pay for performance for physician services. For services provided to Medicare beneficiaries from January 1 through December 31, 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. The data were collected via claims using CPT Category II codes and G-codes where CPT codes were not yet available. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data during the second calendar quarter of 2006. Though PVRP ended December 31, 2006, feedback reports for services provided during the third and fourth calendar quarters of 2006 will be made available during 2007.

2008 Considerations

For 2008, quality measures for eligible professionals must be proposed and finalized through rulemaking. According to the statue, the measures shall: (1) have been adopted or endorsed by a consensus organization, such as the AQA Alliance or National Quality Forum (NQF), (2) include measures that have been submitted by a physician specialty, (3) be identified by CMS as having used a consensus-based process for development, and (4) include structural measures, such as the use of electronic health records and electronic prescribing technology. The proposed 2008 quality measures set must be published by August 15, 2007 and finalized by November 15, 2007.

Though the short lead time for implementation of the 2007 PQRI will not allow CMS to offer registry-based or electronic health record-based reporting for 2007, CMS is exploring the use of these reporting mechanisms for 2008. CMS has already begun a series of meetings with representatives of physicians, medical boards, group practices, and therapists to discuss how CMS can promote the use of standardized specifications for centralized, electronic reporting.

Additional Information

Additional information is available on the CMS PQRI Web site at: http://www.cms.hhs.gov/PQRI or by contacting our office at 1-877-567-9232.

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Crossover Purposes: Recognizing Mass Adjustments from Other Types of Adjustments and Claims

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

What You Need to Know

This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR 5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its Coordination of Benefits Contractor (COBC) can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments - Medicare physician fee schedule (MPFS),
- Mass adjustments - other, and
- All other adjustments.

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Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR 5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claredi rejection code returned for the claim along with its description. (See the MLN Matters article at http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf for information on CR 3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information

The official instruction, CR 5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf on the CMS Web site. Attached to CR 5472, you will find the new chapter of the *Medicare Claims Processing Manual* explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

If you have any questions, please contact our office at 1-877-567-9232.

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Services Not Provided Within United States

Key Points

CR 5427 clarifies that payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

Take Note: Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. **For example**, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.

Background

This article and related Change Request (CR) 5427 outlines the limited items and services that are reimbursable by Medicare outside the United States according to Section 1862(a)(4) of the Social Security Act.

The law specifies the following **exceptions** to the "foreign" exclusion:

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
  - emergency arose within the U.S.; or
  - emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists.
- Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with either of the above.

Additional Information

CR 5427 is the official instruction issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R66BP.pdf.

NOTE: The previously published CR 3781 http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3781.pdf also provides information and instructions about services not provided within the United States by defining "United States" for the purposes of the Social Security Act (Section 1814 (f) along with the parameters of this Medicare rule.

If you have questions, please contact our office at 1-877-567-9232.

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Revised Health Insurance Claim Form CMS-1500 (Version 8/05): Revisions to Incomplete or Invalid Claims Instructions

Note: CMS revised this article on March 2, 2007, to correct the Web address for accessing CR 4309. All other information remains the same.

Provider Action Needed

This article is based on Change Request (CR) 5391 which revises the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the National Provider Identifier (NPI) on the revised Form CMS-1500 version 08/05 and updates the references to remark codes in the instructions and revises the instructions to indicate what is consistent with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Affected providers should assure their billing staff are aware of NPI reporting requirements. These changes apply to claims received on or after May 23, 2007.

Background

The Centers for Medicare & Medicaid Services Form 1500 (CMS-1500; Health Insurance Claim Form) has been revised to accommodate the reporting of the National Provider Identifier (NPI). The revised form is designated as Form CMS-1500 (8/05). The revisions to CMS-1500 include additional items for the reporting of the NPI. The manual revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) through the following Change Requests (CRs):

- CR 4064 at http://www.cms.hhs.gov/Transmittals/Downloads/R777CP.pdf, and MLN Matters article MM 4064 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf;
- CR 4306 at http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf;
- CR 4309 at http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf; and MLN Matters article MM 4309 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf;
- CR 5079 at http://www.cms.hhs.gov/transmittals/downloads/R1055CP.pdf ; and
- CR 5259 at http://www.cms.hhs.gov/transmittals/downloads/R1034CP.pdf.

As a result of the revisions included in the Form CMS-1500 (8/05), the incomplete and invalid claims instructions are being updated to reflect the appropriate items in which the NPI will be reported.
CR 5391 instructs Medicare contractors (carriers, DMERCs, DME MACs, and A/B MACs):

- To make all necessary changes to their internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the Medicare Claims Processing Manual (Pub. 100-04), Chapter One (Sections 80.3.2.1.1 through 80.3.2.1.3) included as an attachment to CR 5391, and the Health Care Claim Professional 837 Implementation Guide (http://www.wpc-edi.com/) for further information.

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- To use the appropriate remittance advice remark codes provided in the Medicare Claims Processing Manual, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.
- To not search their internal files:
  - To correct a missing or inaccurate NPI on a Form CMS-1500(8/05) or on an electronic claim.
  - To correct missing or inaccurate information required for HIPAA compliance for electronically submitted claims governed by HIPAA.

Additional Information

For complete details, please see the official instruction issued to your Medicare contractor (carrier, DMERC, A/B MAC, or DME MAC) regarding this change. That instruction may be viewed on CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf.

If you have any questions, please contact our office at 1-877-567-9232.

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Jurisdiction for Equipment, Supplies, Orthotics and Prosthetics: Which Contractor Processes the Claim?

- The CMS Web site contains a jurisdiction spreadsheet by procedure code. Currently, the most recent jurisdiction list available is for calendar year 2006. The jurisdiction spreadsheet is available on the CMS Durable Medical Equipment (DME) Web page: http://www.cms.hhs.gov/center/dme.asp
  - Generally, claims for DME, prosthetics, orthotics, and supplies are submitted to the DME Medicare Administrative Contractor (DMAC) ***unless*** the device or item is implanted. Claims for implanted DME must be submitted to Palmetto GBA.

- The January 2007 *Coding and Reimbursement Update* contains:
  - Payment amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including splints and casts
  - A list of splint and cast codes that are "carrier jurisdiction" (submitted to Palmetto GBA)

Joint Jurisdiction

These codes have "joint jurisdiction," meaning that they may be submitted to Palmetto GBA or to National Government Services (the DMAC for beneficiaries residing in Ohio or West Virginia), depending on certain criteria.

HCPCS Code	Description	Submit to Palmetto GBA, IF:
A4310-A4359	Incontinence supplies/ urinary supplies	Provided in the physician's office for a **temporary condition**
A4361-A4434	Ostomy supplies	Provided in the physician's office for a **temporary condition**
A5051-A5093 and A5102-A5200	Additional ostomy supplies	Provided in the physician's office for a **temporary condition**
A9900	Miscellaneous DME supply or accessory	Used with **implanted** DME
A9999	Delivery	Used with **implanted** DME
E0781	Ambulatory infusion pump	The infusion is initiated in the physician's office, and the patient **does** return during the same business day
E1340	Repair or non-routine service	Used with **implanted** DME
E1399	Miscellaneous DME	Used with **implanted** DME
L7500-L7520	Repair of prosthetic device	Repair of **implanted** prosthetic device

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HCPCS Code	Description	Submit to Palmetto GBA, IF:
L8499	Unlisted procedure for miscellaneous prosthetic service	Repair of **implanted** prosthetic device
L9900	Miscellaneous orthotic or prosthetic component or accessory	Repair of **implanted** prosthetic device

These supplies are considered carrier jurisdiction; however, they are **not** payable by Palmetto GBA if they are provided "incident to" a physician's service (do not submit these to AdminaStar):

HCPCS Code(s)	Description
A4206-A4209	Medical, surgical, and self-administered injection supplies
A4211	
A4213-A4215	
A4221-A4250	
A4265	Paraffin
A4305-A4306	Disposable drug delivery system
A4450-A4455	Tape; adhesive remover
A4462	Abdominal dressing
A4481	Tracheostomy supply
A4556-A4558	Electrodes; lead wires; conductive paste
A4595	TENS supplies
A4614	Peak flow rate meter
A4615-A4629	Oxygen and tracheostomy supplies
A4649	Miscellaneous surgical supplies
A6010-A6024	Surgical dressing
A6154-A6411	Surgical dressing (except if supply is for implanted prosthetic device or implanted DME – in this case, submit to Palmetto GBA)

Other Tips

- Injections that are administered "incident to" a physician's service are submitted to Palmetto GBA.
- Contact lenses and glasses are submitted to the DMEMAC.

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- Generally, if the item or service is related to an implanted prosthetic device or DME, claims are submitted to Palmetto GBA.
- If you submit a claim to the wrong carrier, the claim will be rejected as a billing error (remark code MA130).
- Claims for DME, prosthetics, orthotics, and supplies all require the name and UPIN of the referring/ordering provider, *even if* this provider is the same provider who is submitting the claim. When these services are submitted without the referring/ordering provider's name and UPIN, they will be rejected (remark code MA130) and must be resubmitted with this information.

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Administrative Simplification Compliance Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims: Temporary Addition

Provider Types Affected

Physicians and providers submitting co-payment reimbursement claims to Medicare carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare patients.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5488 which informs Medicare carriers and A/B MACS that a temporary waiver to a requirement of the Administrative Simplification Compliance Act (ASCA) is being granted for certain claims as discussed in this article.

What You Need to Know

An exception has been created in CR 5488 that instructs carriers and A/B MACs, who use the Medicare Multi-Carrier System (MCS) for claims processing, to grant a temporary ASCA waiver (until July 1, 2007) for Electronic Media Claim (EMC) MSP claims to allow processing of MSP claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer Managed Care Organization (MCO).

What You Need to Do

Participating Medicare providers must not accept from the patient any co-payment, or coinsurance, upon services rendered when the primary payer is an employer MCO insurance, or any other type of primary insurance. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Administrative Simplification Compliance Act (ASCA) requires that claims must be submitted to Medicare electronically. CR 5488 instructs MCS contractors (carriers and A/B MACs) to grant a temporary waiver (until July 1, 2007) for Electronic Media Claim (EMC) MSP claims to allow processing of MSP claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer Managed Care Organization (MCO). Therefore, until July 1, 2007, MCS carriers and A/B MACs are instructed to temporarily:

- Allow for co-payment reimbursement claims to be submitted on paper, and
- Send reimbursement directly to the patient.

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Additional Information

The official instruction, CR 5488, issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1194CP.pdf.

If you have any questions, please contact our office at 1-877-567-9232.

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Common Billing Errors to Avoid When Submitting Medicare Claims

Provider Action Needed

This special edition article includes some general information regarding the most frequent errors that are found in claims submitted to Medicare carriers. The article is intended to help you correctly complete your Medicare claims so they will not be denied, rejected, or delayed because of incorrect or incomplete information.

Background

The Administrative Simplification Compliance Act and its implementing regulation (42 CFR 424.32, http://www.gpoaccess.gov/cfr/retrieve.html) require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003 (except from small providers with limited exceptions).

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. A "small provider" is defined in the Federal Register (42 CFR 424.32(d)(1)(vii), http://www.gpoaccess.gov/cfr/retrieve.html). To simplify, Medicare will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 full time employees (FTEs) that bill a Medicare carrier or DMERC to be small. Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

Common Billing Errors

The following list includes common billing errors that you should avoid when submitting your claims to Medicare carriers:

- The patient cannot be identified as a Medicare patient. Always use the Health Insurance Claim Number (HICN) and name as it appears on the patient's Medicare card.
- Item 32 (and the electronic claim equivalent) requires you to indicate the place where the service was rendered to the patient including the name and address –including a valid ZIP code– for all services unless rendered in the patient's home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word "SAME" in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (**NOTE:** *References to an item number, such as item 32, refer to paper claim forms. However, note that the whenever an article number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims.*)
- The referring/ordering physician's name and UPIN were not present on the claim. Please keep in mind this information is required in Item 17 and 17a on all diagnostic services, including consultations. In addition, be aware of the new requirements for use of National Provider Identifiers (NPIs). To learn

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more about NPIs and how to obtain your NPI, see the *MLN Matters* article SE 0679 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf on CMS' Web site. Also, see the *MLN Matters* articles SE 0555, SE 0659, and MM 4203 for important information regarding CMS' schedule for implementing the NPI. The articles are at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf, http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0659.pdf, **and** http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf, respectively.

- Evaluation and management (E/M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (Example: Procedure code 99283, which is an emergency room visit, is submitted with place of service 11, which is office.)
- Please keep in mind, when billing services for more than one provider within your group, that you must put the individual provider number in Item 24k, as Item 33 can only accept one individual provider number. Also, please make sure the provider number on the claim is accurate and that it belongs to the group. (Also, remember that as of May 23, 2007, NPIs are to be used.)
- Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.
- Procedure code/modifier was invalid on the date of service. Remember that, as of January 1, 2005, CMS no longer provides a 90-day grace period for billing discontinued CPT/HCPCS codes. (**Note:** *Please read the Medicare provider bulletins, especially at the end of each year, as Medicare list all the additions, deletions, and code changes for the following year.*)
- Claims are being submitted with deleted procedure codes. This information can also be found in the CPT Book. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

Billing Tips

The following topics will assist you with correct billing and help you complete and submit error free claims:

A. Provider Numbers

Individual vs. Group PIN - Use the individual rendering provider identification number (PIN) on each detail line. Make sure the group number, when applicable, corresponds to the appropriate individual PIN. When a physician has more than one PIN (private practice, hospital, etc.), use the appropriate PIN for the services rendered. A rendering provider number, if not a solo number, must always belong to the group number that is billing. Electronic submitter ID numbers (not UPINs) should be entered in place of the PIN (group or individual). When billing any service to Medicare, if you have doubts as to which provider number to use, please verify with your carrier. (Remember to use NPIs on claims as of May 23, 2007.)

"Zero-Filling" - Do not substitute zeros or a submitter identification number where a Medicare PIN, UPIN, or NPI is required.

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B. Health Insurance Claim (HIC) Numbers

HIC Accuracy – Your carrier receives numerous claims that are submitted with invalid or incorrect HIC numbers. These claims require manual intervention and can sometimes result in beneficiaries receiving incorrect EOMB information. Please be certain the HIC number you are keying is entered correctly, and is also the HIC that belongs to the patient (based on what is on his/her Medicare card) for which you are billing.

HIC Format - A correct HIC number consists of 9 numbers immediately followed by an alpha suffix. Take special care when entering the HIC number for members of the same family who are Medicare beneficiaries. A husband and wife may have a HIC number that share the same Social Security numerics. However, every individual has their own alpha suffix at the end of the HIC number. In order to ensure proper claim payment, it is essential that the correct alpha suffix is appended to each HIC. *No hyphens or dashes should be used.*

"Railroad Retirees" - Railroad Retirement HIC numbers generally have two alpha characters as a prefix to the number. These claims should be billed to United Health Care Insurance Company, at this address:

Palmetto Government Benefit Administrators
Railroad Medicare Services
PO Box 10066
Augusta, GA 30999-0001

C. Name Accuracy

Titles should not be used as part of the name (e.g., Dr., Mr., Rev., M.D., etc.). Be sure to use the name as it appears on the patient's Medicare card.

Non-Medicare Claims - Do not send claims for non-Medicare beneficiaries to your Medicare carrier.

D. Complete Address

U.S. Postal Addressing Standards - It is very important to meet the U.S. Postal addressing standards. Patient and provider information must be correct. This is necessary so that checks and Medicare Summary Notices (MSNs) or remittance notices arrive at the correct destination. It is also to ensure the quickest service to your office.

- A deliverable address may contain both a street name and number or a street name with a Post Office (P.O.) Box number.
- A P.O. Box by itself is acceptable.
- A Rural Route (RR) number must be with a box number. Note: It is incorrect to key P.O. in front of the box number when given with a rural route.
- A star route number is not a deliverable address. Use highway contract route (HC) instead of star route.
- RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then the box number.
- A box number or a RR number by itself is not deliverable.

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- A street name without a number can not be delivered.
- Do not use % or any other symbol when denoting an "in care of" address. C/O is appropriate.
- As always, no commas, hyphens, periods, or other special characters should be used.

Nursing Home or Skilled Nursing Facility Address - For a facility such as a nursing home or skilled nursing facility, it is preferred that a street name and number be supplied. In some cases, this information is not available, but if it is, please use it. Please verify the accuracy of your address before you send this information.

Apartment Complex - An apartment complex (words such as apartments, towers, or complex indicate such) should contain a street address and an apartment number. Again, this information is not always available, but should always be used when it exists.

Development Center / Trailer Park - If a development center or trailer park is given, it should contain the street address and number, if that information is part of the complete address.

"No Street Address" (NSA) - NSA (No Street Address) **is not acceptable**. This is not a deliverable address.

Changes to Provider Address - Please notify your carrier in writing of any address changes for your office practice.

E. Diagnosis and Procedure Codes

Make sure you keep current with valid diagnosis and procedure codes. HIPAA requires that Medicare conform to these standard code sets reported codes must be valid as of the date of service. Remember that Medicare can no longer allow a grace period for using deleted codes.

Additional Information

Medicare Claims Processing Manual

The *Medicare Claims Processing Manual* (Publication 100-04) contains detailed instructions on Medicare's claims processes and detailed information on preparation and submission of claims. This manual is available on CMS' Web site at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

MLN Matters

MLN Matters is a series of articles that CMS prepares especially for providers. These articles provide information on new and/or deleted procedure and diagnosis codes, changes to the Medicare Physician Fee Schedule and other changes that impact physicians and providers. These articles are available on CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/.

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Listservs

Listservs are electronic mailing lists that CMS uses to get new information into the hands of physicians and providers as quickly as possible. To get your Medicare news as it happens, join the appropriate listserv(s) at http://www.cms.hhs.gov/apps/mailinglists/ on CMS' Web site.

If you have any questions, please contact our office at 1-877-567-9232.

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Ascorbic Acid Injections

Ascorbic Acid, commonly known as Vitamin C, is considered a self-administered substance. However, injectable ascorbic acid may be medically necessary for individuals with malabsorption syndromes. Effective for claims processed on or after, April 1, 2007, the medical record must document the rationale and effectiveness for injectable use.

To submit claims for Ascorbic Acid Injections for malabsorption syndromes, use the following codes:

- HCPCS code J3490 - unclassified drug and enter "injectable ascorbic acid" in the narrative field along with the NDC number and dosage.
- CPT code 90772 – Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular.
- ICD-9 code 579.8 – Other specified intestinal malabsorption or 579.9 – Unspecified intestinal malabsorption.

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Taxonomy Codes & Descriptions

Provider Action Needed

Impact to You

CMS has released the summary of changes reflected in the Health Care Provider Taxonomy Code (HPTC) list version 7.0. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on April 1, 2007.

What You Need to Know

The Health Insurance Portability and Accountability Act (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant.

What You Need to Do

Please review the information included here and stay current on all HIPAA requirements to assure timely processing of your claims.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. The Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction.

HIPAA requires that submitted data, which is part of a named code set, must be valid data from that code set. The health care provider taxonomy is a named code set in the 837 professional implementation guides and carriers must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTCs are updated twice per year, in April and October. The summary of changes for Version 7.0 is noted in the following table:

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Type of Change	Provider Taxonomy Value Code
Additions	• 207LH0002X : Hospice and Palliative Medicine • 207PH0002X : Emergency Medicine: Hospice and Palliative Medicine • 207QH0002X : Family Medicine: Hospice and Palliative Medicine • 202C00000X : Independent Medical Examiner • 207RH0002X : Internal Medicine: Hospice and Palliative Medicine • 207VH0002X : Obstetrics & Gynecology: Hospice and Palliative Medicine • 2080H0002X : Pediatrics: Hospice and Palliative Medicine • 202K00000X : Phlebology • 2081H0002X : Physical Medicine & Rehabilitation: Hospice and Palliative Medicine • 2084D0003X : Psychiatry & Neurology: Diagnostic Neuroimaging • 2084H0002X : Psychiatry & Neurology: Hospice and Palliative Medicine • 2084P0015X : Psychiatry & Neurology: Psychosomatic Medicine • 2085D0003X : Radiology: Diagnostic Neuroimaging • 2085H0002X : Radiology: Hospice and Palliative Medicine • 2086H0002X : Surgery: Hospice and Palliative Medicine • 102L00000X : Psychoanalyst • 103TH0004X : Psychologist: Health • 103TP0016X : Psychologist: Prescribing (Medical) • 111NI0013X : Chiropractor: Independent Medical Examiner • 172M00000X : Mechanotherapist • 172P00000X : Naprapath • 222Q00000X : Developmental Therapist • 242T00000X : Perfusionist • 247ZC0005X : Clinical Laboratory Director, Non-physician

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Type of Change	Provider Taxonomy Value Code
Revisions	• 207Q00000X: Family Medicine • 2084P0802X : Addiction Psychiatry • 2084P0804X : Child & Adolescent Psychiatry • 2084N0600X : Clinical Neurophysiology • 2084F0202X : Forensic Psychiatry • 2084P0805X : Geriatric Psychiatry • 2084N0400X : Neurology • 2084N0402X : Neurology with Special Qualifications in Child Neurology • 2084P0800X : Psychiatry • 2084V0102X : Vascular Neurology • 103G00000X : Clinical Neuropsychologist • 103T00000X : Psychologist • 103TB0200X : Cognitive & Behavioral Psychologist • 103TC2200X: Clinical Child & Adolescent Psychologist • 103TP2701X: Group Psychotherapy • 251S00000X: Community/Behavioral Health Agency
Inactivation (will be deleted in future version)	• 103GC0700X : Clinical Neuropsychologist, Clinical • 103TE1000X : Educational Psychologist • 103TM1700X : Psychologist: Men & Masculinity • 103TW0100X : Psychologist: Women • 103TP2700X: Psychologist: Psychotherapy

The HPTC code list is available from the Washington Publishing Company at http://www.wpc-edi.com.

If you have any questions regarding this article, feel free to call the Ohio and West Virginia EDI Technical Support help line at 1-866-308-5438.

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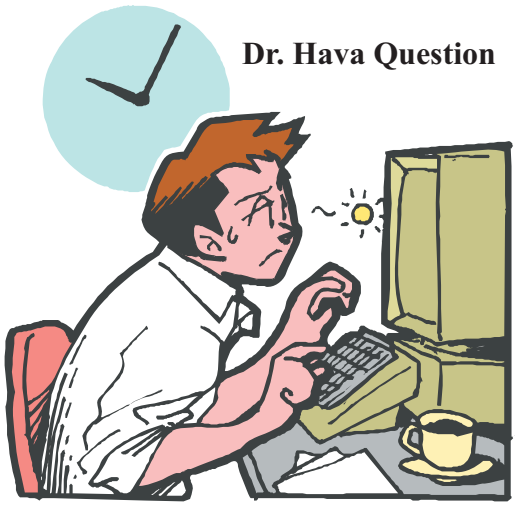
Palmetto Place



Medicare is so confusing. It never stays the same…they are always changing some rule or another. I just can't keep up. Argh!

What is this button on my desk? I've never seen it before....let's try it out.

Wow! Work is so much easier now that I receive Palmetto GBA's email notifications about Medicare Part B changes. I can spend much more time with my patients and the office is running so smoothly.

My wish has come true and yours can too!
Don't delay....sign up today.

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Medicare Part B Small Provider Forum: Springfield, Ohio

Palmetto GBA is sponsoring a General Medicare Part B Seminar in Springfield, Ohio designed for small providers. This forum is specifically designed for providers with fewer than 10 full time employees. The session will include Medicare updates and reimbursement changes and be followed up with a question and answer session. All specialties are welcome!

Date: Wednesday, April 18, 2007

Location: Clark County Public Library, Gaier Room,
201 S. Fountain Ave.
Springfield, OH 45506

Topics and Time: Medicare Updates (1:00 pm – 4:00 pm)

How to Register - The Springfield Area Small Provider Forum
Registration is easy! To register through the Internet, follow these steps:

- Ohio providers: access the Palmetto GBA Web site at http://www.PalmettoGBA.com/boh/education
- Select Workshops

You will need to log in with your username and password to register. In order to register for a seminar, you must first create a username and password. For additional questions regarding registration, please call 1-877-567-9232.

No Internet access?
If you do not have Internet access, you may register for this event by faxing the registration form on the next page to 614-473-6812.

If you have any additional questions, you may contact us at 1-877-567-9232. Select option 3 then option 7.

Please review your schedule and sign up today!

Continued on next page

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Registration Form: Palmetto GBA Small Provider Forums

Please complete the following information and FAX it to Palmetto GBA, Attention: Cari Phillips, 614-473-6812

Name: _____

Practice Name: _____

Practice Address: _____

_____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

_____ April 18, 2007, Springfield, OH

Name and number of persons attending: _____

To Be Completed by Palmetto GBA

_____Your reservation has been received and confirmed for the Small Provider Forum presented by Palmetto GBA. We look forward to seeing you. Due to the varying temperatures in the meeting rooms, you may wish to bring a sweater or jacket to the seminar.

_____We regret that the Small Provider Forum you registered for is full. You may wish to register for another seminar. Please check our Web site at http://www.PalmettoGBA.com/BOH/education (Ohio) or http://www.PalmettoGBA.com/BWV/education (West Virginia) to view available seminars.

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One-on-One Small Provider Appointments: Springfield, Ohio

Palmetto GBA is accepting requests for Medicare Part B One-on-One Small Provider Appointments!

Date: Wednesday, April 18, 2007

Time: 8:00 am to 12:00 pm

This is an excellent opportunity for you to meet with a Community Education Administrator… one-on-one! We will provide you with individualized education and address your specific Medicare concerns. Please be sure to submit your request for an appointment by April 13, 2007. Complete the Meeting Fax form on the following page and fax the form to 614-473-6812 along with the all topics and questions to be discussed during the appointment.

A Palmetto GBA representative will contact you by April 17, 2007, to confirm the time and location of your appointment or to make alternate arrangements.

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Palmetto GBA Medicare Part B Carrier
Ohio & West Virginia Meeting Request Form

Fax to 614-473-6812 to the attention of Medicare Community Education Department

Meeting Date and Time of Day Requested:

Date	Start Time	End Time
_____	_____	_____

Optional Dates and Times:

Date	Start Time	End Time
_____	_____	_____
_____	_____	_____

Group/Individual Sponsoring Event _____

Contact Person _____ Contact Phone _____ Fax _____

E-mail _____ Registration Web Address _____

Meeting Facility _____

Meeting Facility Address _____

City _____ State _____ Zip Code _____

Facility Phone _____

- Approximate number attending _____ (update as needed)
- Submission of this form does not guarantee the date requested. The Medicare Community Education Administrators will contact your office to confirm.

Types of disciplines attending, i.e., physicians, office managers, billers, etc., and provider specialty

_____

_____

Directions to Facility (Enclose or fax map, if available.)

_____

_____

Requested Agenda Topics

_____

_____

As a service, we are now listing any educational meetings on our provider Web site as "Open" (public welcome) or "Closed." If the meeting is listed as "Open" we will print the location, the contact person's name, phone number, email address, and/or registration Web site address. This is done so that others outside of your organization interested in attending can contact you for details. If "Closed," no information except the city, state, and date will be listed. If you do not specify "Open" or "Closed," we will list as OPEN.

Meeting Open _____ Closed _____

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Free Evaluation & Management Medicare Part B Seminars

Palmetto GBA is presenting FREE Evaluation & Management Seminars in Ohio/WV designed for physicians, medical coders, and office managers. Representatives from Palmetto GBA will provide the latest Medicare guidelines for selecting and documenting the appropriate level of evaluation and management codes.

Seating is limited. Reservations are required and will be accepted on a first-come, first-served basis.

Ohio Seminars

Date	Location	Time
Wednesday, May 16, 2007	Holiday Inn 5513 Milan Rd. Sandusky, Ohio 44870	9:00 a.m. – 12:00 p.m.
Wednesday, August 1, 2007	Holiday Inn/Muskingum Valley Conference Center 4645 East Pike Zanesville, Ohio 43701	9:00 a.m. – 12:00 p.m.

West Virginia Seminars

Date	Location	Time
Wednesday, May 30, 2007	Brier Inn 540 N. Jefferson St. Lewisburg, WV 24901	9:00 a.m. – 12:00 p.m.
Wednesday, August 29, 2007	Clarion Hotel & Conference Center 233 Lowe Drive Shepherdstown, WV 25443	9:00 a.m. – 12:00 p.m..

Registration:

To Register for a seminar go to:

- http://www.PalmettoGBA.com/boh/education (Ohio) or http://www.PalmettoGBA.com/bwv/education (West Virginia)
- Workshops

You will need to login with your username and password to register. In order to register for a seminar, you must first create a username and password.

Please call 1-877-567-9232 and select the option for education for additional questions.

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Psychiatric Services: Regulatory Impact and Medicare Guidelines & Integrating Regulatory Requirements and Good Clinical Practice Workshop

When: Friday, June 8, 2007
Where: Heritage Golf Club, Hilliard
Time: 12 (Noon) - 4 p.m.
CE Credits: 4.0
Registration: http://www.ohpsych.org
Registration Deadline: May 30, 2007

This seminar is sponsored by the Ohio Psychological Association (OPA)
Cost:

- $100 OPA Member
- $125 Non-OPA Member
- $75 Office Staff

Meals: A boxed lunch will be provided.

Palmetto GBA and the Ohio Psychological Association (OPA) are presenting a **Psychiatric Services Seminar** designed for psychologists, psychiatrists and their staff members. Representatives from Palmetto GBA will provide the latest Medicare documentation guidelines for Psychiatric Services.

Don't miss out on this Medicare educational seminar to find out the latest Medicare changes and how they may affect you!

Participants will learn:

- Medicare and Palmetto GBA guidelines regarding psychotherapy, pharmacologic management, neuropsychological and psychological testing
- Special provisions and documentation requirements for services provided in teaching facilities
- Correct documentation through tips and hands-on review of sample progress notes
- How the latest Medicare initiatives affect clinical psychologists

The Integrating Regulatory Requirements and Good Clinical Practice session of the workshop will address the issues facing mental health professionals while balancing clinical decisions and strategies with regulatory mandates.

Participants will learn:

- How to make progress notes clinically meaningful while meeting HIPAA guidelines
- Documentation of medical necessity in progress notes
- Goal setting and documenting progress toward goals while meeting HIPAA and Medicare regulations
- Treatment versus maintenance in psychological interventions with older adults

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2007 Medicare Physician Fee Schedule Database (MPFSDB): April Update

Background

This article and related Change Request (CR) 5528 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS Final Rule. CR 5528 amends those payment files.

The following table reflects the key changes from CR 5528:

CPT code & HCPCS modifier	ACTION
17311	• Multiple Procedure Indicator – 0
17313	• Multiple Procedure Indicator – 0
36478	• Transitional Non-Facility PE RVU = 41.71 • Fully Implemented Non-Facility PE RVU = 26.53 **(Informational Only)**
37210	• Transitional Non-Facility PE RVU = 79.88 • Fully Implemented Non-Facility PE RVU = 79.88 **(Informational Only)**
77056 Global	• Fully Implemented Non-Facility PE RVU = 1.96 **(Informational Only)** • Fully Implemented Facility PE RVU = 1.96 **(Informational Only)**
77056 – TC	• Fully Implemented Non-Facility PE RVU = 1.72 **(Informational Only)** • Fully Implemented Facility PE RVU = 1.72 **(Informational Only)**
93225	• Transitional Non-Facility PE RVU = 1.14 • Fully Implemented Non-Facility PE RVU = 0.85 **(Informational Only)** • Transitional Facility PE RVU = 1.14 • Fully Implemented Facility PE RVU = 0.85 **(Informational Only)**
93226	• Transitional Non-Facility PE RVU = 1.93 • Fully Implemented Non-Facility PE RVU = 1.18 **(Informational Only)** • Transitional Facility PE RVU = 1.93 • Fully Implemented Facility PE RVU = 1.18 **(Informational Only)**
93231	• Transitional Non-Facility PE RVU = 1.32 • Fully Implemented Non-Facility PE RVU = 0.71 **(Informational Only)** • Transitional Facility PE RVU = 1.32 • Fully Implemented Facility PE RVU = 0.71 **(Informational Only)**
93232	• Transitional Non-Facility PE RVU = 1.97 • Fully Implemented Non-Facility PE RVU = 1.34 **(Informational Only)** • Transitional Facility PE RVU = 1.97 • Fully Implemented Facility PE RVU = 1.34 **(Informational Only)**

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CPT code & HCPCS modifier	ACTION
95991	• Transitional Facility PE RVU = 0.17 • Fully Implemented Facility PE RVU = 0.18 **(Informational Only)**

The codes in the following table are either bundled or not valid for Medicare purposes. Values for these codes have been established as a courtesy to the general public. These codes will remain bundled or not valid for Medicare purposes even though relative value units have been established.

CPT code	ACTION
78351	• Transitional Non-Facility PE RVU = 1.41 • Fully Implemented Non-Facility PE RVU = 0.47 **(Informational Only)**
98960	• Transitional Non-Facility PE RVU = 0.57 • Fully Implemented Non-Facility PE RVU = 0.57 **(Informational Only)** • Transitional Facility PE RVU = 0.57 • Fully Implemented Facility PE RVU = 0.57 **(Informational Only)**
98961	• Transitional Non-Facility PE RVU = 0.27 • Fully Implemented Non-Facility PE RVU = 0.27 **(Informational Only)** • Transitional Facility PE RVU = 0.27 • Fully Implemented Facility PE RVU = 0.27 **(Informational Only)**
98962	• Transitional Non-Facility PE RVU = 0.20 • Fully Implemented Non-Facility PE RVU = 0.20 **(Informational Only)** • Transitional Facility PE RVU = 0.20 • Fully Implemented Facility PE RVU = 0.20 **(Informational Only)**

The following are revisions to the current MPFSDB:

		NON-FACILITY SETTING			FACILITY SETTING		
CPT Code	State	PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
36478	OH	$1,718.74	$1,632.80	$1,877.72	$327.67 *	$311.29 *	$357.98 *
	WV	$1,546.42	$1,469.10	$1,689.47	$325.14 *	$308.88 *	$355.21 *
37210	OH	$3,210.45	$3,049.93	$3,507.42	$493.78 *	$469.09 *	$539.45 *
	WV	$2,878.12	$2,734.21	$3,144.34	$493.04 *	$468.39 *	$538.65 *

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		NON-FACILITY SETTING			FACILITY SETTING		
CPT Code	State	PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
93225	OH	$43.26	$41.10	$47.27	$43.26	$41.10	$47.27
	WV	$40.04	$38.04	$43.75	$40.04	$38.04	$43.75
93226	OH	$73.41	$69.74	$80.20	$73.41	$69.74	$80.20
	WV	$68.05	$64.65	$74.35	$68.05	$64.65	$74.35
93231	OH	$50.73	$48.19	$55.42	$50.73	$48.19	$55.42
	WV	$47.37	$45.00	$51.75	$47.37	$45.00	$51.75
93232	OH	$74.46	$70.74	$81.35	$74.46	$70.74	$81.35
	WV	$68.72	$65.28	$75.07	$68.72	$65.28	$75.07
95991	OH	$82.49 *	$78.37 *	$90.13 *	$34.35	$32.63	$37.52
	WV	$77.16 *	$73.30 *	$84.30 *	$34.89	$33.15	$38.12

NOTE: * No change in the MPFSDB amount.
(State = Ohio (OH) and West Virginia (WV), PAR = Participating (Non-Facility Setting) fee schedule amount, NON PAR = Nonparticipating (Non-Facility Setting) fee schedule amount, LMT CHG = Limiting charge applies to the Nonparticipating (Non-Facility Setting) fee schedule amount, #F PAR = Facility Setting Participating fee schedule amount, #F NON PAR = Facility Setting Nonparticipating fee schedule amount, #F LMT CHG = Limiting charge applies to Facility Setting Nonparticipating fee schedule amount. Limiting charge applies to unassigned claims by a nonparticipating provider in or out of a facility setting).

These changes are effective January 1, 2007. However, providers may wish to note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

CR 5528 is the official instruction (CR 5528) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1188CP.pdf on the CMS Web site.

If you have questions, please contact our office at 1-877-567-9232.

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Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule: April 2007 Update

Provider Action Needed

This article is based on Change Request (CR) 5537, which provides the April 2007 quarterly update to the DMEPOS fee schedules 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. Be sure billing staff are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis 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 updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; (http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf).

CR 5537 provides specific instructions regarding the April quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

Key Changes

The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

HCPCS codes L8690 and L8691

The A/B MACs, Local Carriers, and FIs will adjust previously processed claims for HCPCS code L8690 (Auditory Osseointegrated Device, Includes All Internal and External Components) and HCPCS code L8691 (Auditory Osseointegrated Device, External Sound Processor, Replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

HCPCS Code E1002 (Wheelchair accessory, Power Seating System, Tilt Only)

HCPCS code E1002 was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code included systems with tilts less than 45 degrees from horizontal. As described in the November 2006 Policy Article for Wheelchair Options/Accessories, power tilt seating systems (falling under HCPCS code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly update, **the fee schedule amounts for HCPCS code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.**

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

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HCPCS code E2377 (Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics and Mounting Hardware, Upgrade Provided at Initial Issue)
HCPCS code E2377 was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for HCPCS code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. **Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.**

Further Changes for Power Wheelchairs
CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

Additional Information
The official instruction, CR 5537, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1203CP.pdf.

If you have any questions, please contact our office at 1-877-567-9232.

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Prostate Cancer Screening Coverage for Eligible Medicare Beneficiaries

Provider Action Needed

This article conveys no new policy that requires provider action. The article is for informational purposes only and serves as a reminder that Medicare provides coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations.

Introduction

Effective for services furnished on or after January 1, 2000, Medicare Part B covers annual preventive prostate cancer screening tests/procedures for the early detection of prostate cancer. The information in this Special Edition *MLN Matters* article reminds health care professionals about the coverage criteria, eligibility requirements, frequency parameters, and correct coding when submitting claims for prostate cancer screening services so that you can talk with your Medicare patients about this preventive benefit and file claims properly for the screening service.

The Screening Services Defined

A. Screening Digital Rectal Examination (DRE)

Medicare defines a screening DRE as a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse midwife who is authorized under State law to perform the examination, fully knowledgeable about the patient's medical condition, and would be responsible for explaining the results of the examination to the patient.

B. Screening Prostate Specific Antigen (PSA) Tests

Medicare defines a screening PSA as a test that measures the level of prostate specific antigen in an individual's blood. This screening must be ordered by the patient's physician (doctor of medicine or osteopathy) or by the patient's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is fully knowledgeable about the patient's medical condition, and would be responsible for explaining the results of the test to the patient.

Coverage Information

Medicare Provides Coverage of the Following Prostate Cancer Screening Tests

- Screening digital rectal examination (DRE), and
- Screening prostate specific antigen (PSA) blood test.

Eligibility & Frequency

Medicare provides coverage of an annual preventive prostate cancer screening PSA test and DRE once every 12 months for all male patients age 50 and older (coverage begins the day after the patient's 50th birthday), if at least 11 months have passed following the month in which the last Medicare-covered screening DRE or PSA test was performed for the early detection of prostate cancer.

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Calculating Frequency
When calculating frequency, to determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

Example: The patient received a screening PSA test in January 2006. The count starts beginning February 2006. The patient is eligible to receive another screening PSA test in January 2007 (the month after 11 months have passed).

Deductible & Coinsurance/Co-payment
- The screening PSA blood test – is a lab test for which neither the deductible nor coinsurance/co-payment apply.
- The screening DRE – the Medicare Part B deductible and coinsurance/co-payment apply.

Claim Filing Information
The following Healthcare Common Procedure Coding System (HCPCS) codes and diagnosis code must be reported when filing claims for prostate cancer screening services:

HCPCS Codes	Code Descriptors
G0102	Prostate cancer screening; digital rectal examination
G0103	Prostate cancer screening; prostate specific antigen test (PSA), total

Diagnosis Code	Description
V76.44	Prostate cancer screening digital rectal examinations (DRE) and screening prostate specific antigen (PSA) blood tests must be billed using screening ("V") code V76.44 (Special Screening for Malignant Neoplasms, Prostate).

Important Note: When submitting claims for the annual preventive prostate cancer screening PSA test it is important to bill for a screening test, which is covered once every 12 months, and not for a diagnostic test.

Payment for Prostate Cancer Screening Services
- Screening PSA tests (HCPCS code G0103) – are paid under the clinical diagnostic laboratory fee schedule.
- Screening DREs (HCPCS code G0102) – are paid under the Medicare Physician Fee Schedule (MPFS) except for the following bill types identified (FI only). Bill types not identified are paid under the MPFS.
  - 12X, 13X, and 14X* = Outpatient Prospective Payment System

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- 71X and 73X = Included in All Inclusive Rate
- 85X = Cost (Payment should be consistent with amounts paid for CPT code 84153 or CPT code 86316.)

* Effective 4/1/2006, the type of bill 14X is for non-patient laboratory specimens.

Additional Notes:

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) should include the charges on the claims for future inclusion in encounter rate calculations.
- Billing and payment for a DRE (HCPCS code G0102) is bundled into the payment for a covered evaluation and management service (CPT codes 99201 – 99456 and 99499) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise non-covered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

Additional Information

For more information about Medicare's Prostate Cancer screening benefit, visit the CMS Prostate Screening Web page: http://www.cms.hhs.gov/ProstateCancerScreening/ on the CMS Web site.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.
- The CMS Web site provides information for each preventive service covered by Medicare. Visit http://www.cms.hhs.gov, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit http://www.medicare.gov/ on the Web.

Medicare patients can obtain information about Medicare preventive benefits at http://www.medicare.gov/ and then click on "Preventive Services". They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Colorectal Cancer: Preventable, Treatable, and Beatable! Medicare Coverage and Billing for Colorectal Cancer Screening

Provider Action Needed

Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible patients, age 50 and older, to get screened for colorectal cancer. This Special Edition *MLN Matters* article highlights coverage changes that became effective January 1, 2007 and reviews Medicare coverage and billing processes for colorectal cancer screening.

What You Need to Know

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

What You Need to Do

Be sure your staff is aware of this coverage and the CMS urges physicians to encourage their patients to take advantage of this important coverage.

Background

Colorectal cancer is the second leading cause of cancer death in the U.S., and the third most common type of cancer. In 2006, colorectal cancer was expected to account for 55,170 deaths and 148,610 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. **The data currently available (1998- 2002) indicate the Medicare colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period** and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends ("A" rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. There are insufficient data to determine which screening strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective (less than $30,000 per additional year of life gained) regardless of the strategy chosen. To read the full recommendation, go to the following link: http://www.ahrq.gov/clinic/uspstf/uspscolo.htm.

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The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on 2 criteria--burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value. To read about the ranking of clinical preventive services, go to the following link: http://prevent.org/content/view/46/96/.

Risk Factors

Patients are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Coverage Information

Medicare covers the following colorectal cancer screening tests and procedures:

- **Fecal occult blood test (FOBT)**: Medicare covers 1 FOBT annually for beneficiaries 50 and older. A written order from the patient's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for 1 FOBT, not both, per year. Patients do not have to pay coinsurance for the FOBT, and do not have to meet the annual Medicare Part B deductible.

  Note: In 2006, and effective for services provided January 1, 2007 and later, CMS adopted the more specific CPT code 82270 (patient was provided 3 single cards or single triple card for consecutive collection) and discontinued the G HCPCS code G0107 (FOBT, 1-3 simultaneous determinations) to encourage quality colorectal cancer screening practices. Two studies published in January 2005 in the *Annals of Internal Medicine* suggested that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up.

- **Screening flexible sigmoidoscopy**: Medicare covers a screening flexible sigmoidoscopy once every 4 years for beneficiaries 50 and older. If a patient had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

- **Screening colonoscopy**: Medicare coverage for a screening colonoscopy is based on patient risk. For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers 1 screening colonoscopy every 10 years, but not within 47 months of a previous screening flexible sigmoidoscopy. For beneficiaries considered to be at high risk for developing colorectal cancer,

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Medicare covers 1 screening colonoscopy every 2 years, regardless of age. A screening colonoscopy must be performed by a doctor of medicine or osteopathy.

- **Screening barium enema**: Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy for all beneficiaries under the same coverage requirements and at the same frequency as for the screening flexible sigmoidoscopy. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening flexible sigmoidoscopy or the barium enema, but not both.

  Medicare also covers a barium enema as an alternative to a screening colonoscopy rendered to a patient at high risk for developing colorectal cancer under the same coverage requirements, at the same frequency. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening colonoscopy for the high-risk patient or the barium enema rendered in lieu of it, but not both.

  A screening barium enema must be ordered in writing and collected by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a patient. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the patient.

  The patient is liable for paying 20% of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema. **See "2007 Changes" for changes to coinsurance amount.**

2007 Changes

Starting January 1, 2007, the Medicare Part B deductible has been waived for **screening** colonoscopy, sigmoidoscopy, and barium enema (as an alternative to colonoscopy or sigmoidoscopy). However, the deductible is not waived if the colorectal cancer screening test becomes a diagnostic colorectal test; that is the service actually results in a biopsy or removal of a lesion or growth.

Starting January 1, 2007, for a screening flexible sigmoidoscopy or a screening colonoscopy performed in a non-outpatient prospective payment system hospital outpatient department, the patient is liable for paying 25% of the Medicare-approved amount (the coinsurance). The 25% coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) for OPPS hospitals. However, it is not being applied to non-OPPS hospitals.

Starting January 1, 2007, for a screening colonoscopy performed in an ambulatory surgical center, the patient is liable for paying 25% of the Medicare-approved amount (the coinsurance).

In addition, HCPCS code G0107 (FOBT, 1-3 simultaneous determinations) has been discontinued. CPT code 82270 (patient was provided 3 single cards or single triple card for consecutive collection) has been adopted to encourage quality colorectal cancer screening.

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How to Bill Medicare

The following Healthcare Common Procedure Coding System/Current Procedure Terminology (HCPCS/CPT) codes should be used to bill for colorectal cancer screening services:

CPT Code	Code Descriptors
82270	Colon cancer screening; FOBT, patient was provided 3 single cards or single triple card for consecutive collection
HCPCS Code	**Code Descriptors**
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105*	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
G0122**	Colon cancer screening; barium enema (non-covered)
G0328	Colon cancer screening; fecal occult blood test, immunoassay

* When billing for the "high risk" patient, the screening diagnosis code on the claim must reflect at least one of the high risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer screening chapter of the Guide to Preventive Services. This guide is available at: http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf.

**Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (HCPCS code G0104) or covered screening colonoscopies (HCPCS code G0105). However, there may be instances when the patient has elected to receive the barium enema for colorectal cancer screening other than specifically for these purposes. In such situations, the patient may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These non-covered barium enemas are to be identified by HCPCS code G0122 (colorectal cancer screening; barium enema). HCPCS code G0122 should not be used for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The patient is liable for payment of the non-covered barium enema.

If billing Carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

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If billing Intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal cancer screening chapter of the Guide to Preventive Services. Once again, this guide is available at: http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf on the CMS Web site.

Reimbursement information is also provided in this guide.

Additional Information

CMS has developed a comprehensive prevention Web site that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes Web site links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society. http://www.cms.hhs.gov/ColorectalCancerScreening/

Other MLN Matters articles on colorectal cancer screening changes mentioned in this special edition are MM 5387 (coinsurance changes) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf and MM 5127 (deductible change) http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.

The CMS Web site provides information for each preventive service covered by Medicare. Visit http://www.cms.hhs.gov/ , select “Medicare”, and scroll down to “Prevention”.

For products to share with your Medicare patients, visit http://www.medicare.gov.

Medicare beneficiaries can obtain information about Medicare preventive benefits at *http://www.medicare.gov/* and then click on “Preventive Services”. They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information about National Colorectal Cancer Awareness Month, please visit *http://www.crfa.org/colorectal/*.

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One-Time Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) Screening

Provider Action Needed

This article conveys no new policy information. This article is for informational purposes only and serves as a reminder that Medicare provides coverage of a one-time initial preventive physical examination and a one-time preventive ultrasound screening for abdominal aortic aneurysms subject to certain coverage, frequency, and payment limitations. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out and to encourage eligible beneficiaries to take full advantage of these benefits and all preventive services and screenings covered by Medicare.

Background

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries, as a result of Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, to include coverage under Medicare Part B of a one-time IPPE, also referred to as the "Welcome to Medicare" physical exam, for all Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act (DRA) of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at risk beneficiaries as part of the IPPE. Both benefits (the IPPE and AAA) are subject to certain eligibility and other limitations.

The information in this Special Edition *MLN Matters* article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their "Welcome to Medicare" physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their "Welcome to Medicare" physical exam.

Benefit Coverage Summary Benefit Coverage Summary

The Initial Preventive Physical Examination ("Welcome to Medicare" Physical Exam)

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. The IPPE must be received by the beneficiary within the first six months of their Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors,
2. A review of an individual's potential (risk factors) for depression,
3. A review of the individual's functional ability and level of safety,
4. An examination to include an individual's height, weight, blood pressure measurement, and visual acuity screen,

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5. Performance of an electrocardiogram (EKG) and interpretation of the EKG,
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements, and
7. Education, counseling, and referral (including a brief written plan such as a checklist provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

Important reminders about the IPPE:

- The IPPE is a unique benefit available only for beneficiaries new to the Medicare Program and must be received within the first six months of the effective date of their Medicare Part B coverage.
- This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

The Part B deductible and coinsurance/copayment apply to this benefit.

Note: The deductible does not apply for an IPPE provided in a Federally Qualified Health Center (FQHC). Only the coinsurance/copayment applies.

Other preventive services and screenings covered under Medicare Part B include: Adult immunizations (flu, pneumococcal, and hepatitis B), bone mass measurements, cardiovascular screening, diabetes screening, glaucoma screening, screening mammograms, screening Pap test and pelvic exam, colorectal and prostate cancer screenings, diabetes self-management training, medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease, and smoking and tobacco-use cessation counseling. Benefits are subject to certain eligibility and other limitations.

NOTE: The IPPE/"Welcome to Medicare" physical exam does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the preventive services and screenings that are currently covered and paid for by Medicare Part B. (See the ***Additional Information*** section below for links to *MLN Matters* articles MM 3771 and MM 3638, which provide detailed coverage criteria and billing information about the IPPE benefit.)

Preventive Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their "Welcome to Medicare" physical exam. There is no Part B deductible applied to this benefit, but coinsurance/copayment applies.

IMPORTANT NOTE: Only Medicare beneficiaries who receive a referral from their physician or other qualified non-physician practitioner for the preventive ultrasound screening, as part of their "Welcome to

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Medicare" physical exam, will be covered for the AAA benefit. (See the ***Additional Information*** section below for a link to *MLN Matters* article MM 5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Additional Information

For more information about Medicare's coverage criteria and billing procedures for the AAA and IPPE benefits, refer to the following *MLN Matters* articles:

- MM 5235 (2006), *Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination*, http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf
- MM 3771 (2005), *MMA – Clarification for Outpatient Prospective Payment system (OPPS) Hospitals Billing the Initial Preventive Physical Exam (IPPE),* http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3771.pdf
- MM 3638 (2004), *MMA – Initial Preventive Physical Examination,* http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf

CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.

The CMS Web site provides information for preventive service covered by Medicare. Visit http://www.cms.hhs.gov, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit http://www.medicare.gov/ on the Web.

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Frequently Asked Questions: Medical Review

Can a consultation service be submitted as a split/shared visit?

Answer:
A consultation shall not be performed as a split/shared Evaluation and Management (E/M) visit.

The split/shared Evaluation and Management (E/M) policy does not apply to consultation services, critical care services or procedures.

A split/shared E/M visit is a medically necessary encounter with a patient where the physician and a qualified NPP each perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. A split/shared E/M visit applies only to selected E/M visits and settings.

The split/shared E/M policy does not apply to consultation services, critical care services or procedures.

Resources:
http://www.cms.hhs.gov/manuals
Internet-Only Manual Publication # 100-04, Chapter 12: Physicians/NonPhysician Practitioners 30.6.10

What documentation is required for Transtelephonic monitoring?

Answer:
In order for transtelephonic monitoring services to be covered, the services must consist of the following elements:

- A minimum 30-second readable strip of the pacemaker in the free-running mode;
- Unless contraindicated, a minimum 30-second readable strip of the pacemaker in the magnetic mode; and
- A minimum 30 seconds of readable ECG strip

* Medical necessity of a service is the overarching criterion for payment. The medical necessity for services provided must still be documented in the medical record.

Resources:
The guidelines for "Cardiac Pacemaker Evaluation Services" are available on the Centers for Medicare and Medicaid Service's (CMS's) Web site at: http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf

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"General Ophthalmological Services" vs. Evaluation and Management (E/M) Codes

You are about to submit a claim for an eye exam.

Question: Should you submit the service using the appropriate code for general ophthalmological services (CPT codes 92002, 92004, 92012, and 92014) or an Evaluation and Management (E/M) code?

Answer: It depends on your documentation. Read more about how the requirements for the two code sets differ.

Documentation is Key

- Whether you opt to submit a general ophthalmological services code or an E/M code, your documentation must support the code you submit.
- Your documentation must meet or exceed the requirements for submitting the code.

General Ophthalmological Services

There are two levels of general ophthalmologic services, intermediate and comprehensive as described below.

- These codes are appropriate for services to new or established patients when the level of service includes several routine optometric/ophthalmologic examination techniques, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and motor evaluation, which are integrated with and cannot be separated from the diagnostic evaluation. Itemization of individual service components is not applicable.

- The physical examination elements of an ophthalmologic examination are ten (10) in number and include:

  - Confrontation visual fields
  - Eyelids and adnexa
  - Ocular mobility
  - Pupils/iris
  - Cornea
  - Anterior Chamber
  - Lens
  - Intraocular pressure
  - Retina (vitreous, macula, periphery, and vessels)
  - Optic disc

- A **comprehensive examination** consists of eight or more elements, and always includes a fundus examination with the pupils dilated.

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- An **intermediate examination** consists of seven or fewer of the specified elements.
- When billing for denial purposes, **correction of refractive errors** should be submitted using CPT code 92015. There should not be an additional evaluation and management charge. No payment will be made for CPT code 92015 and an E/M code.

Evaluation and Management (E/M) Services

- Services that require minimal optometric/ophthalmologic examination techniques are reported with the E/M CPT codes (99201-99799).
- The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) jointly developed the E/M Documentation Guidelines. The initial guidelines were developed in 1995. A second set of guidelines was developed in 1997. You may use either set when determining the correct E/M code to submit, but you may not "mix and match" between both sets.
- The level of E/M code generally depends on the extent to which the key components are documented and the medical necessity of the level of service. Depending upon the code, two or three of these key components must be documented at the required "level" in order to submit a specific CPT code:
  - History (including chief complaint; history of present illness; past, family, and social history; and review of systems)
  - Examination (specified by the affected body area or system and may include other body areas/ systems)
  - Medical decision making (including number of diagnoses or management options; amount/ complexity of medical records, diagnostic tests, and/or other information that must be analyzed; risk of significant complications, morbidity, and/or mortality; comorbidities; associated with the presenting problem, diagnostic procedure, and/or possible management options)
- Key differences between the 1995 and 1997 E/M Documentation Guidelines include the way chronic or inactive conditions are considered, for purposes of History of Present Illness, and the specificity of requirements for the Examination component.

Reference

- The *CPT Assistant*, January 2007, Volume 17, Issue 1 contains a related Q&A on this topic.
- Take advantage of free training offered by Palmetto GBA clinical education staff to learn more about how to understand and apply the E/M Documentation Guidelines. To view a list of upcoming workshops or to download E/M educational guides, go to:
  - http://www.PalmettoGBA.com/boh/education (Ohio providers)
  - http://www.PalmettoGBA.com/bwv/education (West Virginia providers)
- Conduct internal audits of documentation vs. code selections.
- Consider using a standardized "scoring tool" for consistency in applying the E/M Documentation Guidelines. Palmetto GBA publishes one such tool on our Web site, although there are many others from which to choose.
- Review the Palmetto GBA FAQs for Medical Review.
  - Ohio offices: go to http://www.PalmettoGBA.com/boh/resources, then select FAQs, Medical Review.
  - West Virginia offices: refer to http://www.PalmettoGBA.com/bwv/resources, then select FAQs, Medical Review.

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Laboratory National Coverage Determination (NCD) Edit Software: April 2007 Changes

Provider Action Needed

This article and related Change Request (CR) 5514 announces the changes that will be included in the April, 2007 release of the edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). You may want to assure your billing staff is aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its claims processing systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective April 1, 2003. The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Section 120.2., available on CMS' Web site at http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct Current Procedural Terminology (CPT) codes to reflect the current CPT update.

CR 5514 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after April 1, 2007.

Key Point of CR 5514

Effective for dates of service on or after April 1, 2007:

- The **new HCPCS code G0394** for Blood Occult Test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection) is added to the list of HCPCS codes for the Fecal Occult Blood Test NCD (190.34).

Additional Information

If you have questions, please contact our office at 1-877-567-9232.

To see the official instruction (CR 5514) issued to your Medicare carrier, FI, or A/B MAC, go to http://www.cms.hhs.gov/Transmittals/downloads/R1200CP.pdf on the CMS Web site.

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New Waived Tests

Provider Action Needed

CR 5484, from which this article is taken, notifies your carriers and A/B MACs of the new Food and Drug Administration (FDA)-approved tests (effective October 4, 2006) that are waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), so that they can accurately process your claims.

Background

First, remember that CLIA regulations require a laboratory facility to be appropriately certified for each test it performs. Further, to ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Some specific background about waived tests may, at this point, also be helpful. These new laboratory tests (which the FDA approves on a flow basis) are valid (and marketed) as soon as they are approved. Therefore, as soon as informed by the FDA of the test approvals, the Centers for Medicare & Medicaid Services (CMS) must immediately notify the carriers and A/B MACs so that they are ready to process claims when submitted. CR 5484, from which this article is taken, announces the latest tests approved by the FDA as waived tests under CLIA. These tests are described in the bulleted paragraph (below), and displayed in red/bold print in Table 1, that follows. Note that each of the Current Procedural Terminology (CPT) codes for these new tests must have the HCPCS modifier QW to be recognized as a waived test, and that these new waived tests are effective on October 4, 2006.

New FDA Waived Tests Under CLIA

- CPT code 82042 and HCPCS modifier QW has been assigned for the albumin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT 82150 and HCPCS modifier QW has been assigned for the amylase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT 82247 and HCPCS modifier QW has been assigned for the total bilirubin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT 82977 and HCPCS modifier QW has been assigned for the gamma glutamlytransferase (GGT) test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT code 84075 and HCPCS modifier QW has been assigned for the alkaline phosphatase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT code 84157 and HCPCS modifier QW has been assigned for the total protein test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc) {whole blood}.
- CPT code 84520 and HCPCS modifier QW has been assigned for the urea (BUN) test performed using the Arkray SPOTCHEM EZ Chemistry Analyzer.

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Table 1: Latest FDA Waived Tests Under CLIA*

CPT/HCPCS Code & HCPCS Modifier	Effective Date	Description
84450-QW and 84460-QW	August 16, 2005	Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
87899-QW	March 30, 2006	Rapid Pathogen Screening RPS Adeno Detector
86308-QW	July 27, 2006	PerMaxim RediScreen Mononucleosis {Whole Blood}
82274-QW, HCPCS G0328-QW	August 3, 2006	Enterix Insure II Fecal Immunochemical Test
82274-QW, HCPCS G0328-QW	August 9, 2006,	Teco Rapid Fecal Occult Blood (FOB) Card Test
82274-QW, HCPCS G0328-QW	September 22, 2006	OcculTech Fecal Occult Blood Rapid Test
82042-QW, 82150-QW, 82247-QW, 82977-QW, 84075-QW, and 84157-QW	October 4, 2006	Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
84520-QW	October 4, 2006	Arkray SPOTCHEM EZ Chemistry Analyzer {whole blood} for urea (BUN)
84450-QW	October 5, 2006	Arkray SPOTCHEM EZ Chemistry Analyzer{whole blood} for aspirate amminotransferase (AST)(SGOT)
85018-QW	October 10, 2006	HemoCue Hb 301 System
87999-QW	October 16, 2006	Genzyme Diagnostics OSOM BVBlue Test
87880-QW	November 1, 2006	Inverness Medical BioStar Acceava Strep A Test
80101-QW	November 14, 2006	Branan Medical Corporation, QuickTox Drug Screen Dipcard
80101-QW	November 14, 2006	Branan Medical Corporation, FasTox Multiple Drug Dipcard
86308-QW	November 22, 2006	LifeSign Status Mono {for whole blood}

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* The Current Procedural Terminology (CPT) codes for these new tests must have the HCPCS modifier QW to be recognized as a waived test.

In addition, it is also important that you note that the tests displayed in table 2, below, do **not** require a QW HCPCS modifier to be recognized as a waived test.

Table 2: Waived Tests That Do Not Require the QW Modifier

CPT & HCPCS Code(s)	Test Name	Manufacturer	Use
81002	Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Various	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
81025	Urine pregnancy tests by visual color comparison	Various	Diagnosis of pregnancy
82270, 82272 HCPCS G0394 (Contact your Medicare carrier for claims instructions.)	Fecal occult blood	Various	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use	Various	Monitoring of blood glucose levels
83026	Hemoglobin by copper sulfate – non-automated	Various	Monitors hemoglobin level in blood
84830	Ovulation tests by visual color comparison for human luteinizing hormone	Various	Detection of ovulation (optimal for conception)
85013	Blood count; spun microhematocrit	Various	Screen for anemia
85651	Erythrocyte sedimentation rate – non-automated	Various	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia

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Final note: Carriers and A/B MACs do not need to search their files to either retract payment or retroactively pay affected claims processed prior to the implementation of this change, however, they will adjust claims that you bring to their attention.

Additional Information

You can find the official instruction, CR 5484, issued to your carrier or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1195CP.pdf on the CMS Web site. As an attachment to that CR, you will find the complete list of laboratory tests granted waived status under CLIA.

If you have any questions, please contact our office at 1-877-567-9232.

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New Waived Tests: Correction to Change Request 5404

Provider Action Needed

Impact to You

Change Request (CR) 5482, from which this article is taken, corrects information provided in CR 5404 (released November 24, 2006).

What You Need to Know

CR 5404, which informed carriers and A/B MACS about new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA), contained an incorrect Current Procedural Terminology (CPT) code for the Gryphus Diagnostics BVBlue test. The correct code for this test is CPT Code 87999, HCPCS modifier QW (Unlisted microbiology procedure).

What You Need to Do

You should ensure that your billing staffs are made aware of this CPT code correction, and bill accordingly.

Background

CR 5404, which informed carriers and A/B MACS of new waived tests approved by the Food and Drug Administration (FDA) under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), contained an incorrect CPT for the Gryphus Diagnostics BVBlue test. In both the table in the background section of the Recurring Update Notification attachment and in the waived test list attachment, CR 5404 listed the CPT code for the Gryphus Diagnostics BVBlue as CPT code 87899, HCPCS modifier QW.

The CPT code 87899 is for infectious agent activity detection tests by **immunoassay** with direct optical observation; not otherwise specified. In contrast, the Gryphus Diagnostics BVBlue test is an **enzyme activity test** that detects sialidase activity in vaginal fluid specimens and is not an immunoassay test. The code in this table and in the waived test list attachment should have been CPT code 87999 and HCPCS modifier QW (Unlisted microbiology procedure). See the table below for the correct codes.

Note: All the other information in CR 5404 remains the same.

Table 1: CPT Codes for FDA Approved New Waived Tests

CPT Code/HCPCS Modifier	Effective Date	Description
82274-QW, HCPCS code & modifier G0328-QW	June 15, 2006	Immunostics, Inc., hema-screen Specific Immunochemical Fecal Occult Blood Test
87999-QW	June 30, 2006	**Gryphus Diagnostics BVBlue**
83655-QW	September 18, 2006	ESA Biosciences LeadCare II Blood Lead Testing System (whole blood)

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You should remember that the CLIA regulations require a facility to be appropriately certified for each test performed, and that laboratory claims are currently edited at the CLIA certificate level.
Note: Carriers and A/B MACs will not search their files to correct affected claims processed prior to the implementation date of this change, but will adjust any claims that you bring to their attention.

Additional Information

You can find the official instruction, CR 5482, issued to your carrier or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1197CP.pdf.

The MLN Matters article, MM 5404, related to CR 5404 may be found at http://www.cms.hhs.gov/MLNMAttersArticles/downloads/MM5404.pdf.

If you have any questions, please contact our office at 1-877-567-9232.

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Routine Foot Care - *Clarification on Systemic Conditions/Class Findings*

There are specific requirements regarding documentation that must be maintained in medical records when you provide foot care to a Medicare Part B patient. *Although the Palmetto GBA Local Coverage Determination (LCD) for Foot Care has been retired (effective for dates of service on or after 10/1/2005), the Centers for Medicare & Medicaid Services (CMS) has established national-level guidelines governing routine foot care and treatment of mycotic nails. These CMS guidelines are still in effect for routine foot care and treatment of mycotic nails.*

Background

Routine foot care is not a covered Medicare benefit. Medicare assumes that the patient or caregiver will perform these services by themselves, and therefore, they are excluded from coverage. There are certain exceptions to this rule.

What is Medicare's definition of routine foot care?

Routine foot care is defined as:

- The cutting or removal of corns or calluses;
- The trimming, cutting, clipping, or debriding of nails;
- Hygienic and preventive maintenance care such as:
  - Cleaning and soaking the feet;
  - The use of skin creams to maintain skin tone of either ambulatory or bedfast patients;
  - Any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

Are there any exceptions when Medicare would allow routine foot care?

Yes, Medicare allows exceptions to this exclusion when medical conditions exist that place the patient at increased risk of infection and/or injury if a non-professional would provide these services. Medicare may cover routine foot care in the following situations:

- The routine foot care is a necessary and integral part of otherwise covered services
- In certain circumstances, services ordinarily considered to be routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.
- The patient has a systemic condition
- The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. In these instances, certain foot care procedures that otherwise are considered routine (as defined previously) may pose a hazard when performed by a nonprofessional person.

Systemic Conditions

The most common diagnoses that can represent the underlying conditions to justify coverage as exceptions to routine foot care exclusions are:

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- Peripheral vascular conditions and diabetes
  Diabetes mellitus *
  Arteriosclerosis obliterans
  Buerger's disease
  Chronic thrombophlebitis *

- Peripheral neuropathies involving the feet
  Associated with malnutrition and vitamin deficiency *
  - malnutrition
  - alcoholism
  - malabsorption
  - pernicious anemia

  Associated with carcinoma *
  Associated with diabetes mellitus *
  Associated with drugs or toxins *
  Associated with multiple sclerosis *
  Associated with uremia (chronic renal disease) *
  Associated with traumatic injury
  Associated with leprosy and neurosyphilis
  Associated with hereditary disorders
  - Hereditary sensory radicular neuropathy
  - Angiokeratoma corporis diffusum (Fabry's)
  - Amyloid neuropathy

When the patient's condition is one of those designated by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

Class Findings
The severity of one of the above diagnoses that would lead to a consideration of coverage involves documentation of clear evidence of significant circulatory changes defined as:
- 1 Class A finding (submit HCPCS modifier Q7);
- 2 Class B findings (submit HCPCS modifier Q8); or
- 1 Class B and 2 Class C findings (submit HCPCS modifier Q9).

Class A Finding:
- Nontraumatic amputation of foot or integral skeletal portion thereof

Class B Findings:
- Absent posterior tibial pulse
- Absent dorsalis pedis pulse

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- Advanced trophic changes (at least three of the following):
  - Decrease or absence of hair growth
  - Nail thickening
  - Skin discoloration
  - Thin and shiny skin texture
  - Rubor or redness of skin

Class C Findings:
- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesia (abnormal spontaneous sensations in feet)
- Burning

Documentation for Systemic Conditions/Class Findings
Palmetto GBA does not require any documentation to be submitted with the claim for routine foot care services. However, there must be evidence that the patient was under the care of a doctor of medicine or osteopathy during the preceding 6 months. Therefore, the Unique Physician Identification Number (UPIN) or the National Provider Identifier (NPI) of this doctor and the date (8-digits) of the last visit to this doctor must be submitted in the appropriate field of an electronic claim or in Item 19 of the CMS-1500 claim form.

The patient's medical record must document the medical necessity of services performed for each date of service submitted on a claim, and documentation must be available to Medicare on request.

The medical record must document and identify:
- The physician treating the systemic condition
- The approximate last date of treatment by the M.D. or D.O.
- The systemic condition
- The size and exact location of each lesion treated
- The clinical documentation of class findings for each date of service

Mycotic Nails
In the absence of a systemic condition, treatment of mycotic nails may be covered.

The treatment of mycotic nails for an ambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

The treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and

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(2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

For the purpose of these requirements, documentation means any written information that is required by the carrier in order for services to be covered. Thus, the information submitted with claims must be substantiated by information found in the patient's medical record. Any information, including that contained in a form letter, used for documentation purposes is subject to carrier verification in order to ensure that the information adequately justifies coverage of the treatment of mycotic nails.

Frequency

Services performed for excessive frequency are not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and the reason for additional services is not justified by documentation.

Reference:

- CMS Internet Only Manuals (http://www.cms.hhs.gov/manuals/IOM/list.asp):
  - The Medicare Benefit Policy Manual (Pub. 100-02), Chapter 15, section 290.B.2: definition of routine foot care.
  - The Medicare Benefit Policy Manual (Pub. 100-02), Chapter 15, section 290.C.3: exceptions to the routine foot care exclusion.

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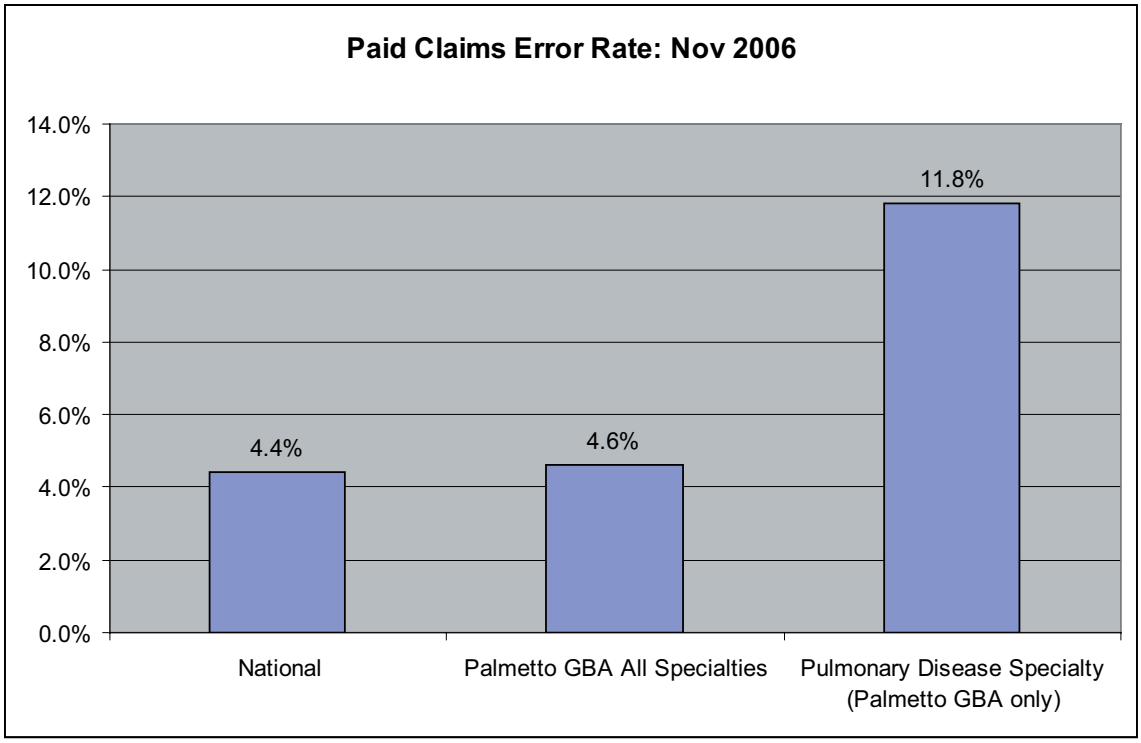
Pulmonary/Respiratory Procedures: Common Errors

The latest results from the Comprehensive Error Rate Testing (CERT) program have arrived. Through the CERT program, accuracy measures for claims submitted to Palmetto GBA and payments that we make are received. We analyze these measures by looking at the national, carrier and specialty specific results. These results are the primary data sources Palmetto GBA uses to assess the effectiveness of our education.

In the November 2006 CERT report, there are several outcomes specifically related to procedures performed by Pulmonary Disease specialists (specialty 29 physicians). This report includes claims submitted from April 2005-March 2006.

- The Paid Claims Error Rate is a measure of the percentage of incorrect payments. The percentage of incorrect payments in the sampled claims is projected across the entire universe of payments for the identified code grouping.
- Pulmonary disease specialists have the 4th highest Paid Claims Error Rate among all Palmetto GBA provider specialty types.



Source: The Supplementary Appendices for the Improper Medicare Fee-for-Service Payments, November 2006 report, p. 34.

Among paid claims errors, the code group with the most errors is Evaluation and Management (E/M) codes. Pulmonary Disease specialists are one of four specialty types that account for the majority of E/M codes submitted to Palmetto GBA. Of the E/M codes, the four highest are represented in the following chart.

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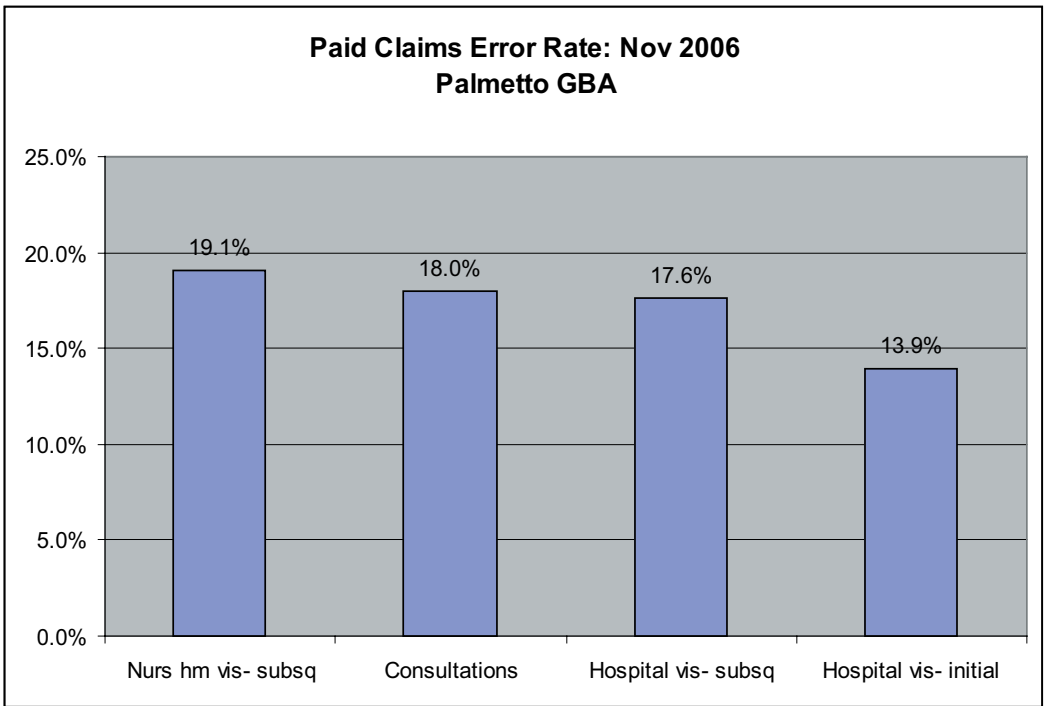

Source: Comprehensive Error Rate Testing (CERT) Program, List of Over-Utilized Codes Report, p. 18.

Preventing Errors

- We strongly encourage all providers and their staff members to become familiar with the E/M Documentation Guidelines, which were developed jointly by CMS and the American Medical Association.
- Take advantage of free training offered by Palmetto GBA clinical education staff to learn more about how to understand and apply the E/M Documentation Guidelines. To view a list of upcoming workshops in Ohio, go to http://www.PalmettoGBA.com/boh/education. For West Virginia workshops, refer to http://www.PalmettoGBA.com/bwv/education. If you are unable to attend a Palmetto GBA workshop, you may download two helpful workshop handouts from our Education Web page:
  - Evaluation and Management Documentation Guidelines Educational Packet
  - Hospital Evaluation & Management Services Educational Packet
- Conduct internal audits of documentation vs. code selections, especially for E/M services.
- Consider using a standardized "scoring tool" for consistency in applying the E/M Documentation Guidelines. Palmetto GBA publishes one such tool on our Web site, although there are many others from which to choose.
- Review the Palmetto GBA FAQs for Medical Review.
- Ohio offices: go to http://www.PalmettoGBA.com/boh/resources, then select FAQs, Medical Review.
- West Virginia offices: refer to http://www.PalmettoGBA.com/bwv/resources, then select FAQs, Medical Review.

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Lumbar Artificial Disc Replacement (LADR): Coding Changes

Note: This article was revised on February 1, 2007, to show the correct CPT code of 0163T in the last bullet point. The article had incorrectly reflected CPT code 0263T. All other information remains the same.

Effective for services performed on or **after January 1, 2007**, carriers will **deny claims**, for Medicare beneficiaries over sixty years of age, submitted with the following codes:

- CPT code 22857 for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace.

- CPT Category III code 0163T for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace.

Carriers and A/B MACs will continue to follow their normal claims processing criteria for investigational device exemptions (IDEs) for LADR performed with an implant eligible under the IDE criteria.

Carriers will allow claims submitted for approved IDEs/clinical trials submitted with:

- CPT codes 0091T or 0092T for services performed from May 16, 2006 through December 31, 2006.

- CPT codes 22857 or 0163T for services preformed on or after January 1, 2007 with the HCPCS modifier QA.

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Medical Director's Desk Robert R. Kamps, M.D.

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

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

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

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

CMS is recommending that coverage be consistent throughout a contractor's jurisdiction. In order to comply with this request, we will be consolidating the Ohio and West Virginia LCDs with the South Carolina LCDs. This will lead to LCD retirements and revisions that will be identified in this article. Future LCDs will be created jointly with South Carolina. The Carrier Advisory Committee members for all 3 states will have input into the creation of any new LCDs, and all new LCDs will have open comment periods during which providers or other interested parties from Ohio, West Virginia or South Carolina will be able to comment.

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Local Coverage Determination Updates

LCD	Change	Effective Date
Ocular Photography and Ophthalmoscopy 2001-52LR15	Addition of ICD-9 codes 190.5, 190.6, 190.8, 224.5, 224.6 and 224.8 as supporting medical necessity for CPT code 92240. Addition of ICD-9 codes 053.20, 053.21, 053.22, 054.41, 364.42, 376.30, 870.0 - 870.9, and 871.0-871.9 as supporting medical necessity for CPT codes 92285. Added language under *Indications and Limitations* section regarding ICG in the assessment of choroidal hemangioma.	3/01/2007
Bone Mass Measurement 2001-37LR15	Deletion of CPT code 78350. This code is a status N effective 01/01/07.	2/21/2007
C-Reactive Protein Testing 2005-04LR2	Language changes for clarification under *Indications and Limitations* section.	2/21/2007

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292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433
ICD9 Primary Code	**ICD9 Alternative Specific Code**	**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and Examples (not all-inclusive)**	**HCPCS Crosswalk**
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick Person - Fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433

Emergency Conditions—Trauma

959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition Specific" Column	A0427/A0433
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433

	904.9.					
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429
ICD9 Primary Code	**ICD9 Alternative Specific Code**	**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and Examples (not all-inclusive)**	**HCPCS Crosswalk**
880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433

869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0427/A0433

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429

994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near Drowning	Airway compromised during near drowning event.	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference Codes 959.8, 958.2, 869.0/869.1	A0427/A0433
ICD9 Primary Code		**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and examples (not all-inclusive)**	**HCPCS Crosswalk**

995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429
Non-Emergency						
428.9		Cardiac/hemodynamic monitoring required en route.		ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.		ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.		BLS	Per transfer instructions.	A0428

786.09		Airway control/positioning required en route.		BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428
ICD9 Primary Code		**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and examples (not all-inclusive)**	**HCPCS Crosswalk**
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - in restraints.		BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428
293.1		Patient Safety: Danger to self or others - monitoring.		BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428

298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - seclusion (flight risk).		BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428
ICD9 Primary Code		**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and examples (not all-inclusive)**	**HCPCS Crosswalk**

041.9		Special handling en route - isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain - orthopedic device.		BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428

719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route - positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures — post-op hip as an example	A0428	

Transportation Indicators

Transportation Indicators Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C1	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434

C2	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW		A0428, A0429, A0426, A0427, A0433, A0434
C3	Emergency Trauma Dispatch Condition Code	Major Incident or Mechanism of Injury	**Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.**	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS Response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS Transport of ALS-level Patient	ALS-Level Condition treated and transport by a BLS-level ambulance	**This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.**	BLS		A0429

Transport Description Modifiers Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C6	ALS-level Response to BLS-level Patient	ALS Response Required based upon appropriate Dispatch Protocols - BLS-level patient transport	**Indicates to Carrier/Intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare Ambulance Fee Schedule.**	ALS		A0427
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.	ALS	Does not apply to self-administered IV medications.	A0426

Air Ambulance Transportation Indicators

Air Ambulance Transportation Indicators		Transportation Indicator Description	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
D1		Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2		Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3		Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.	FW, RW		A0430, A0431
D4		Pick-up point not accessible by ground ambulance	FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be crosswalked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.

Medicare Part B Refund & Overpayment Form

This form, or a similar document, containing the following information should accompany every voluntary refund to properly record and apply a refund. Please complete and forward to Medicare.

Provider Information
(Must be Completed)

Name: _____
Address: _____
_____
_____
Provider Number: _____
Contact Person: _____
Provider/Office Personnel Signature:
_____

Overpayment/Refund Information
(Each Patient Must be Identified. Use an Attachment; if needed)

Patient's Name: _____
Medicare Number (HIC) (Include Suffix):
_____
Claim Number(s) _____
Service Date(s): _____
Procedure Code: _____
Overpaid Amount: _____

For OIG Reporting Requirements
Do you have a Corporate Integrity Agreement with OIG? Yes ☐ No ☐

Medicare Secondary Payer Reason For Overpayment

*(Must be completed for MSP overpayments. Please **circle** the appropriate number. For multiple overpayments, please identify each reason. Use an attachment, if needed)*

Please include a copy of the primary insurance remittance for the service(s) in question

Medicare Secondary Payer (MSP)

01 Group Health Plan Insurance _____
02 No Fault Insurance _____
03 Liability Insurance _____
04 Workers Compensation _____
05 Black Lung _____
06 Veterans Administration _____
07 ESRD _____
08 Other Insurance Involvement
(Please Identify) _____

Secondary Insurance:

Insurance Name: _____
Insurance Address: _____
Insured's Name: _____
Employee's ID Number: _____
Primary Payer's Allowance: _____
Primary Payer's Payment: _____
Please send a check for the entire amount of the claim when the primary insurance payer has not been determined.

Reason For Overpayment/Refund

*(Must be completed for overpayments. Please **circle** the appropriate number. For multiple overpayments, please identify each reason. Use an Attachment, if needed)*

01 Incorrect Service Date
(Specify Correct Date) _____
02 Duplicate Payment
(Specify Correct Information) _____
03 Incorrect CPT Code
(Specify Correct CPT Code) _____
04 Not Our Patient(s)
05 Modifier Added or Removed
(Specify Correction) _____
06 Billed in Error _____
07 Service Not Rendered _____
08 Medical Necessity Not Met _____
09 Patient Enrolled in HMO
(Specify HMO) _____
10 Other
(Please Identify) _____

❖ **Please include a corrected claim for *any* service(s) billed incorrectly**

All refund checks must be addressed to:
Palmetto GBA,
Medicare Part B or
Medicare
Any checks addressed differently cannot be accepted for deposit.

Please mail to the following address:
Palmetto GBA
Medicare Part B Debt Collection Unit
P.O. Box 182934
Columbus, OH 43218-2934

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Medicare Opt Out HPSA and/or PSA Bonus Program

Please note that you will NOT RECEIVE ANY HPSA OR PSA BONUS PAYMENTS should you choose to Opt Out of the program.

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

_____

Signature: _____

Date you wish this Opt Out to become effective*: _____

* You may backdate this option to January 1, 2005 (but not prior to that date). The date we receive and approve this form will become the effective date if you do not indicate an effective date above.

By signing this agreement I acknowledge, and choose **not** to receive (I will forgo) the HPSA 10% bonus payments and/or the PSA 5% bonus payments, beginning with the effective date I have indicated above.

If you choose to Opt Out: You will not receive any HPSA or PSA bonus for any service. However, you may submit global services (diagnostic and x-ray) and those services will not reject as unprocessable.

If you choose not to Opt Out: It is not necessary to submit this form if you wish to continue to receive HPSA and/or PSA bonuses. In order to receive these bonuses for applicable services, global charges for diagnostic tests and x-rays (identified with a PC/TC indicator of 4) must be submitted as separate professional and technical components. A bonus will be paid for global services with a PC/TC indicator of 1 based upon a calculation for the professional component of the global service.

For more information please see CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/ (refer to article MM 3827).

If you wish to Opt Out of the HPSA bonus and/or PSA bonus program,
please send completed form to:
Attention: Robert Reese, HPSA/PSA Specialist
Medicare Part B
Palmetto GBA
P.O. Box 182934
Columbus, Ohio 43218-2934

Or FAX completed form to:
Robert Reese, HPSA/PSA Specialist
614 - 473 - 6805
Palmetto GBA
Post Office Box 182934 • Columbus, Ohio • 43218-2934

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Redetermination Request for Medicare Part B Claims

For Ohio & West Virginia

Requests must be filed within 120 days of the date of initial determination.

If you received a Medicare Redetermination on this claim DO NOT use this form to request further appeal. Your next level of appeal is a Reconsideration by a Qualified Independent Contractor (QIC). Use the form with your decision letter or use the appropriate reconsideration request form found on our Web site at http://www.PalmettoGBA.com. If you received message MA-130 on the Medicare Remittance Notice for this claim, no appeal or reopening rights are available. Please submit a NEW claim with the appropriate corrections.

General Information

Patient's name _____

Health Insurance Claim (HIC) number _____

Date of initial determination _____

CPT code(s) _____

ICD-9 code(s) _____

Performing provider number _____

Billing provider number _____

Phone number _____

Date of service _____

This is an appeal for:

___ Ambulance service
___ Chiropractic service
___ CRD/ESRD service
___ Duplicate service
___ Limitation of Liability (LOL) service
___ Podiatry service
___ Psychiatric service
___ Radiology service
___ Other

The following must be submitted with the appeal request, if applicable.

☐ Remittance Notice **(please attach)**
☐ Advance Notice Statement
☐ Claim Copy
☐ Medical Necessity Statement
☐ Office Notes
☐ Operative Report
☐ Radiology Report
☐ Treatment Plan

Reason for request: _____

_____

_____

_____

Requestor (signature required): _____ Date: _____

Address: _____

_____

_____

Palmetto GBA,
Medicare Appeals, QA-Redeterminations, Q555
P.O. Box 182933
Columbus, OH 43218-2933

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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 include the bolded information.** Please include a copy of the redetermination notice and identify the claim number 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: _____
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

3. Provider Name and 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:
☐ Medical Records ☐ A Copy of the Claim ☐ Treatment Plan
☐ Certificate of Medical Necessity ☐ Office Notes / Progress Notes

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 (Carrier 00883)
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 567-9232
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 include the bolded information.** Please include a copy of the redetermination notice and identify the claim number 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: _____
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

3. Provider Name and 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:
☐ Medical Records ☐ A Copy of the Claim ☐ Treatment Plan
☐ Certificate of Medical Necessity ☐ Office Notes / Progress Notes

11. Printed Name of Person Appealing:

12. Signature of Person Appealing: _____ **Date:** _____

13. Phone Number of Person Appealing: _____

Contractor Number: 00884

Palmetto GBA – West Virginia Medicare Part B Carrier (Carrier 00884)
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 567-9232
A CMS Contracted Intermediary and Carrier

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Call Center
1-877-567-9232 (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

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

http://www.PalmettoGBA.com

Important Sources For You

- http://www.cms.hhs.gov
- http://www.cms.hhs.gov/MLNGenInfo
- http://www.cms.hhs.gov/forms
- http://www.cms.hhs.gov/QuarterlyProviderUpdates
- http://www.cms.hhs.gov/MedicareProviderSupEnroll/

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

Attention: Billing Manager

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Columbus, Ohio
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