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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

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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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Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: October 2007 Update

What Providers Need to Know

The 2007 Fiscal Intermediary (FI) annual update Major Category IV A. Mammography Screening CPT codes (**77055 and 77056**), that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS) are **REMOVED** with a retroactive effective date of January 1, 2007. CR 5636, on which this article is based, removes these two codes from the FI file.

Healthcare Common Procedure Coding System (HCPCS) codes **Q1001 and Q1002** are added to the File 1 Coding file and are effective for dates of service prior to June 30, 2005. Please refer to the *Background* and *Additional Information* sections for more information.

Background

Periodically, the Centers for Medicaid & Medicare Services (CMS) updates the lists of HCPCS codes (for FIs carriers and DME/MACs) that are subject to the consolidated billing provision of the SNF PPS. This particular update, however, applies to providers who bill for NTIOLs furnished in ASCs as well as providers billing Medicare FIs for Major Category IV. A. Mammography Screening. The mammography codes for screening and diagnostic mammography services that are **no longer valid as of January 1, 2007** are:

- Diagnostic mammography, unilateral—CPT code **77055**
- Diagnostic mammography, bilateral—CPT code **77056**

NTIOLs that are now reimbursable separately by the carrier/MAC for dates of service prior to June 30, 2005 are:

- **HCPCS code Q1001** (Category 1, AMO Array Multifocal lens: Model # SA40N); and
- **HCPCS code Q1002** (Category 2, Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens).

In addition, Medicare edits allow the payment of the \$50 additional fee for Category 3 NTIOLs for dates of service prior to January 1, 2007, when billed with HCPCS code **Q1003**. (See MM 4361 for additional information about NTIOLs and HCPCS code **Q1003** and the article may be found at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM4361.pdf>.)

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on the list of services included in SNF CB.
- Conversely, Medicare will pay non-SNF providers for beneficiary services **excluded** from SNF PPS and CB, even when in a SNF stay.

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- SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

FIs, carriers and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

Additional Information

To see the official instruction (CR 5636), go to <http://www.cms.hhs.gov/Transmittals/downloads/R1266CP.pdf>.

Also, MM 3901 is the article that announced the cessation of the additional \$50 payment for NTIOLs for HCPCS codes Q1001 and Q1002 and that article may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3901.pdf>.

You can find more information about the new 2007 mammography CPT codes by going to CR 5327, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf>. There, as an attachment to that CR, you will find revised Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services) of the Medicare Claims Processing Manual (100-04),

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

Notice of New Interest Rate for Medicare Overpayments & Underpayments: 4th Qt. FY 2007

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (four percent for calendar year 2007) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to **12.625 percent** effective **July 20, 2007**.

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

What Providers Need to Know

CR 5643, from which this article is taken, reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

Background

ICD-9- CM codes, became mandatory as follows:

- In 1979 for use in reporting provider services on Form CMS-1450;
- On April 1, 1989, for use by all physician services submitted on Form CMS-1500; and
- On October 1, 2003 for all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59);
 - The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).
 - CMS issued CR 5643 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

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

Additional Information

You can find the official instruction, CR 5643, issued to your Medicare contractor by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf>. As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm>, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for \$25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

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To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage.

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

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Mandatory Medigap (“Claim-Based”) Crossover Process

What Providers Need to Know

CR 5662, from which this article is taken, outlines the processes that Part B carriers, Medicare Administrative Contractors (MACs) responsible for Part B claims processing, and Durable Medical Equipment Medicare Administrative Contractors (DMACs) shall follow in notifying affected parties that the mandatory Medigap (claim-based) crossover process is being transitioned to the Coordination of Benefits Contractor (COBC) effective October 1, 2007

Background

The Centers for Medicare & Medicaid Services (CMS) has decided that, effective October 1, 2007, all mandatory Medigap (“claim-based”) crossovers will now be accomplished through its Coordination of Benefits Contractor (COBC). Further, CMS has decided that, in accordance with Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160, it will **only** –transmit claims to Medigap claim-based crossover recipients in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional (version 4010A1) coordination of benefits (COB) claim format or in the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format. (**NOTE:** The systematic requirements relating to this transition were communicated via change request (CR) 5601, as reflected in *MLN Matters* article MM 5601 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf>.)

Starting with June 2007, CMS’ COBC will gradually begin to assign new Medigap claim-based COBA identifiers (range 55000 to 59999) to Medigap insurers that have not voluntarily moved to the COBA eligibility file-based crossover process. CMS anticipates that the COBC will complete the execution of crossover agreements with Medigap claim-based insurers and assign new COBA Medigap claim-based identifiers to these entities by August 31, 2007. As the COBC assigns a new COBA Medigap claim-based ID to a Medigap claim-based crossover recipient, CMS will alert all Part B contractors, including MACs, and DMACs via e-mail of this action on a weekly basis. The CMS alert will include the following information: affected entity’s name; the entity’s multiple formerly contractor-assigned Other Carrier Name and Address (OCNA) or N-key identifiers; and its newly assigned COBA Medigap claim-based ID. Upon receipt of the CMS alert, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables to replace the formerly assigned OCNA or N-key identifier. Contractors shall also maintain a link to the COB Web site (<http://www.cms.hhs.gov/COBAgreement>) for purposes of receiving updates to the COBA Medigap claim-based ID listing.

The affected contractors shall post CMS’ Medigap claim-based crossover transition announcement in its entirety on their Web sites that are accessed by the public and insurers. These contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients and shall also notify their paper claim recipients through information included with their next scheduled claim mailings.

Providers should note the following: Effective October 1, 2007, the COBC will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on

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the incoming claim. The primary change for providers resulting from this transition will be that they will need to include a new Medigap identifier, even in advance of October 1, 2007, on their incoming Medicare claims to trigger crossovers to Medigap insurers. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit COBA Medigap claim-based identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs for Medicare billing purposes at the following Web site: [http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf](http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf). Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB Web site, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message - 'Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer.' - on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) **left-justified** in field NM109 of the NM1 segment within the 2330B loop **and** followed by spaces. **(See important note that follows regarding the submission of claims to DMACs.)**

Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier **left-justified** within field 301-C1 of the T04 segment of their incoming NCPDP claims **and** followed by spaces.

IMPORTANT: For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007.

Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

Additional Information

You can find the official instruction, CR 5662, at <http://www.cms.hhs.gov/Transmittals/downloads/R283OTN.pdf>.

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Repeat or Duplicate Services on the Same Day

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

Many providers and billing departments re-file claims without allowing sufficient time for the original claim to process. One submission is all that is required. CMS suggests that if you have not received payment after 30 days and are concerned about your payment, contact Palmetto GBA via the toll-free Provider Contact Center at 1-877-567-9232 to check on a claim status through the provider IVR system or you may use other electronic claims status inquiry functions available.

When a correction is needed on a previously paid service, do not submit as a new claim. A redetermination request must be submitted in writing to:

Palmetto GBA,
Medicare Appeals, QA-555
P.O. Box 182933
Columbus, Oh 43218-2933

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

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

Example: Patient receives two chest x-rays on 10/1/06 interpreted by the *same physician*. The first interpretation is performed at 10:00 a.m and the interpretation of the second x ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	71010-26	2

Modifiers

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

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Site Modifiers:

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

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

Submit as:

Date of Service	CPT Code/HCPCS Modifier	Days/Units
10/1/06	28010-T1	1
10/1/06	28010-T3	1

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

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

Example: Patient receives three chest x-rays on 10/1/06 by the *same physician*. The first x-ray is performed at 10:00 a.m., the next one at 12:00 p.m., and a follow-up x-ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	71020	1
10/1/06	71020-76	2

OR submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	71020	3

- The most effective method to ensure timely processing is to use the Days/Units Field and submit all services on one claim.
- **CPT Modifier 77 – “Repeat procedure by another physician”:** A physician may need to indicate that he repeated a service performed by *another physician* on the same day.

Example: Patient receives two EKGs on 10/1/06. The first EKG is taken at 10:00 a.m. and Dr. A performs the interpretation. The second EKG is taken at 1:30 p.m. and Dr. B performs the interpretation.

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Submit as:

Claim #1 – Dr. A

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	93010	1

Claim #2 – Dr. B

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	93010-77	1

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

Example: The patient had two folic acid tests performed on the same day.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	82746	1
10/1/06	82746-91	1

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Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARC) and Enhancement of Medicare Remit Easy Print (MREP)

Provider Action Needed

This article is based on Change Request (CR) 5634 which instructs Medicare contractors that a Remittance Advice Remark Code (RARC) must be used with Claim Adjustment Reason Codes (CARCs) 16, 17, 96, 125, and A1. CR 5634 also instructs that updated Medicare Remit Easy Print (MREP) software will be provided which incorporates enhancements approved by the Centers for Medicare & Medicaid Services (CMS) and the currently valid Claim Adjustment Reason and Remittance Advice Remark Codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions (submission of claims, claims inquiries, electronic remittance advice, etc.) adopted under HIPAA using valid standard codes. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the Transactions and Code Sets Rule selected by HIPAA, and the ANSI X12 subcommittee 'N' covers standards in the insurance industry, including health insurance (hence these are X12N standards). The ANSI ASC X12N transaction number 835 (ANSI ASC X12N-835) is the ANSI standard electronic remittance advice (ERA) transaction that provides payment information on a submitted claim.

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARC) Update

As a reminder, Medicare policy states that:

- Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions, and
- Remittance Advice Remark Codes (RARC) are **required in the remittance advice for both paper and electronic formats.**

When the payment differs from the amount being billed, Payers communicate the reason for any adjustment using:

- **Group Codes** (which identify who is financially responsible for the amount that the payer is not reimbursing),
- **CARC**s (which provide an explanation why an amount is being adjusted), and
- **RARC**s (which provide a supplemental explanation about the adjustment) Any RARC that has the word "Alert" is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication.

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The following table includes Group Codes currently being used by CMS:

Group Code	Definition
CO	Contractual Obligation (Provider is financially responsible)
PR	Patient responsibility (Provider can collect the amount from patient)
OA	Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
CR	Correction (Used with reversal and correction)

The ANSI ASC X12N-835 Implementation Guide (version 004010A1) requires CARCs (if needed) but does not require use of RARCs. A HIPAA compliant version of the Implementation Guide for transaction 835 (Health Care Claim Payment & Remittance Advice) is available at: <http://www.wpc-edi.com/HIPAA>.

The code committee that maintains the CARC code set recently modified five CARCs (16, 17, 96, 125, and A1). These CARCs were selected for modification because they were very generic, and they were used most frequently. Of these 5 CARCs, the following 4 now require the use of at least one appropriate RARC, and they are **effective April 1, 2007**:

CARC	Definition
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

The remaining 1 CARC (which follows) also requires at least one RARC, but it is **effective June 1, 2007**.

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CARC	Definition
A1	Claim denied charges

CMS instructed your Medicare contractor(s) to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any existing RARCs (that are not currently being used) may be appropriate to explain an adjustment. Your Medicare contractor(s) may start using any of the currently existing RARCs with CARCs 16, 17, 96, 125, and A1.

Note: The most current list of RARCs can be found at: <http://www.wpc-edi.com/codes>.

In addition, the committee that maintains reason codes approved the following CARC effective February 28, 2007:

CARC	Definition
204	This service/equipment/drug is not covered under the patient's current benefit plan

Your Medicare contractor(s) may use CARC 204 instead of CARC 96 and an appropriate remark code, e.g., N130.

RARC	Definition
N130	Consult plan benefit documents for information about restrictions for this service

RARC N130 will be used with CARC 96 as a default combination to be reported on all DME claims if:

- No code has been assigned by your Medicare contractor, and
- The service is not covered by Medicare.

Medicare Remit Easy Print (MREP) Enhancement

CMS developed Medicare Remit Easy Print (MREP) software that gives providers a tool to read and print an electronic remittance advice (RA) in a human readable format. Providers who use the MREP software have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claims submissions to secondary/tertiary payers for Coordination of Benefits. Information regarding MREP and instructions on obtaining MREP are available through your Medicare contractor.

In a continuing effort to improve MREP, CMS established a process to receive suggestions to enhance the functionality and effectiveness of MREP from providers, contractors, and CMS staff. The next updated version of MREP that incorporates improvements approved by CMS will be available in July 2007. Note that the timeline for the annual MREP enhancement update has changed from October to July.

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Additional Information

To view the official instruction, CR 5634, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1267CP.pdf>.

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

Health Professional Shortage Area (HPSA): Revision to Internet Only Manual (IOM) Pub 100-04, Chapter 12, Section 90.4

What Physicians Need to Know

CR 5625, from which this article is taken, informs carriers and A/B MACs that they no longer have to maintain a separate Web site of HPSA designated areas for you to use concerning claims for the HPSA bonus payment. Rather, Palmetto GBA's Web site will have links to a Center for Medicare and Medicaid Services (CMS) Web site (<http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>) and a Health Resources and Services Administration (HRSA) Web site (<http://www.bhpr.hrsa.gov/shortage/>). These sites will be available to help you when filing HPSA bonus payment claims.

You should make sure that your billing staffs are aware of these changes.

Background

CMS is simplifying the process of determining designations that are eligible to receive the Health Professional Shortage Area (HPSA) bonus payment; in order to ensure a more accurate method of:

1. Paying claims in areas that are designated for the HPSA bonus payment, and
2. Reducing the risk of overpayments in area that are not designated as HPSA bonus payment areas.

To reflect these changes, Medicare Claims Processing manual (100-04) Chapter 12 (Physician/Practitioner Billing), Section 90.4 (Billing and Payment in a Health Professional Shortage Area (HPSA)) is being updated; and CR 5625, from which this article is taken, revises how Medicare contractors will disseminate information about HPSA bonus payment to the provider community.

Per these revisions, carriers will no longer maintain an updated Web site of HPSA designations for physicians to use when filing HPSA bonus payment claims. The carriers, instead, will be required to provide two direct links for you to use when filing HPSA bonus payment claims. Those links are:

- To the CMS site, to verify automated HPSA bonus designation status, which you can access at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>; and
- To the HRSA site, to verify HPSA bonus designation status, which you can access at <http://www.bhpr.hrsa.gov/shortage/>,

You should be aware that CMS will continue to automatically pay a bonus for those ZIP codes that are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS) and for those ZIP codes that fully fall within a partial county HPSA (effective for services rendered on or after the date of designation by HRSA)

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However, for those ZIP codes that do not fully fall within a full county HPSA or fully within a non full county HPSA, you must continue to enter the AQ HCPCS modifier on the claim in order to receive the bonus.

Additional Information

You can find the official instruction, CR 5625, by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1273CP.pdf>.

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

Health Professional Shortage Area (HPSA): HCPCS Modifiers QB or QU

Impact to You

For dates of service on or after January 1, 2006, when a modifier is required to bill for the HPSA bonus, use **HCPCS modifier AQ** for physician services provided in HPSAs. **Claims will be returned as unprocessable if submitted with HCPCS modifiers QB or QU**, when submitted for dates of service on or after January 1, 2006.

What You Need to Know

Make certain that services eligible to receive a HPSA bonus for dates of service on or after January 1, 2006, are billed with the **HCPCS modifier AQ, when a modifier is required.**

What You Need to Do

Make certain that your billing staffs are aware of these changes.

Background

Under certain circumstances, it is necessary to include a modifier on a claim in order to receive a HPSA bonus payment. The QB and QU HCPCS modifiers are the appropriate modifiers to be submitted for claims with dates of service prior to January 1, 2006. **The AQ HCPCS modifier is the appropriate modifier to be used for dates of service on or after January 1, 2006.**

Per direction from the Centers for Medicare & Medicaid Services (CMS), some Medicare contractors allow claims submitted with the QB and QU HCPCS modifiers with dates of service on or after January 1, 2006 to be submitted and processed, though no bonus payment is made as the correct modifier has not been submitted. According to Health Insurance Portability and Accountability Act (HIPAA) regulations for transactions and code sets, as found in 45 Code of Federal Regulations (CFR) 160, providers must include valid codes and modifiers, as derived from the standard transaction code sets, on their incoming claims submitted to Medicare. Therefore, allowing claims with inappropriate modifiers to be accepted into the Medicare claims processing system constitutes a violation of the HIPAA standard transaction code sets.

In order to comply with HIPAA regulations and allow claims to be forwarded successfully to supplemental payers, **as of October 1, 2007, Medicare will no longer accept claims submitted with the QB or QU HCPCS modifiers for invalid dates of service.** Claims must be submitted with the correct modifiers for the correct dates of service in order to be processed.

Additional Information

For complete details regarding this Change Request (CR), please see the official instruction (CR 5629) by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1275CP.pdf>.

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Additional information on the HPSA bonus and the physician scarcity area bonus can be found at http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/01_overview.asp.

The Guide for Using the HPSA/PSA Web Page can be viewed by going to <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf>.

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

Charges for Missed Appointments

Impact to You

The Centers for Medicaid & Medicare Services (CMS) policy is to allow physicians and suppliers to charge Medicare patients for missed appointments. However, Medicare itself does not pay for missed appointments, so such charges should not be billed to Medicare.

What You Need to Know

Providers may **not charge ONLY** Medicare patients for missed appointments; they must **also charge non-Medicare patients**. The amount the physician/supplier charges Medicare patients for missed appointments must be the same as the amount that they charge non-Medicare patients.

What You Need to Do

Make certain that your billing staff is aware that you may bill the patient directly, that Medicare itself does not make any payments for missed appointments, and that Medicare should not be billed for these charges.

Background

According to Chapter 12, section 30.3.13 of the *Medicare Claims Processing Manual*, which is attached to CR 5613, CMS policy allows physicians, providers, and suppliers to charge Medicare patients for missed appointments, provided that they do not discriminate against Medicare patients but also charge non-Medicare patients for missed appointments and the charges for Medicare and non-Medicare patient are the same. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The other key points of CR 5613 are:

- The provider may bill the Medicare patient directly.
- Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers.
- Claims for missed appointments sent to Medicare will be denied with the reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan.).
- In most instances, a hospital outpatient department can charge a beneficiary a missed appointment charge.
- In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the patient a missed appointment fee.

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Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5613) 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/R1279CP.pdf>.

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

Appeals Transition - BIPA Section 521 Appeals

Provider Action Needed

This article is based on Change Request (CR) 5460, which notifies Medicare contractors about their need to comply with changes to provisions in Chapter 29 of the *Medicare Claims Processing Manual* (Publication 100-04) that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

Background

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act (MMA). The Social Security Act (Section 1869(c)), as amended by BIPA and MMA, requires changes to the Code of Federal Regulations (CFR; Title 42) regarding:

- Appointment of representatives,
- Fraud and abuse,
- Guidelines for writing appeals correspondence, and
- The disclosure of information.

Therefore, the Centers for Medicare & Medicaid Services (CMS) is revising provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes.

The purpose of CR 5460 is to notify Medicare contractors about their need to comply with these revised *Medicare Claims Processing Manual* provisions, which are included as an attachment to CR 5460.

Some of the key changes to the manual direct Medicare contractors to:

- Follow the procedures that define who may be a representative and how a representative is appointed (via the CMS-1696 Appointment of Representative (AOR) form);
 - Do not accept an appointment if the contractor has evidence that the appointment should not be honored;
 - Send notice only to the representative when the contractor takes action or issues a redetermination [if there is an appointed representative];
 - Provide assistance in completing the CMS-1696 form, as needed; and
 - Do not release patient-specific information to a representative before the patient or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

Please note that the **AOR** applies to all services, claims and appeals submitted on behalf of the patient for the duration of the AOR.

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- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider (via the CMS-20031) Transfer of Appeal Rights form):
 - For each new appeal request, a form needs to be submitted, this form is valid for all levels of the appeal process including judicial review, even in the event of the death of the patient;
- If a provider furnishes the service, he/she would be a party to the initial determinations, only providers or suppliers who are not a party may accept assignment of appeal rights from a patient. That is assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment; and
- The provider or supplier who accepts the appeal rights to collect payment from the patient for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form.
- Provide redetermination letters that are understandable to patients.

Please note that an **Assignment of Appeal Rights** is valid for the duration of an appeal unless it is revoked by the patient.

Additional Information

The official instruction, CR 5460, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf>. The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.

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

Provider Inquiries & Provider Customer Service Program Updates

Provider Action Needed

CR 5597 contains a number of revisions to the Medicare Contractor Beneficiary and Provider Communications Manual, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units. While the authentication rules are part of CR 5597, for complete details about these rules under the Medicare NPI contingency plan, see MLN Matters article SE 0721, which you will find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf>.

The remainder of this article provides information on the highlights of changes announced in CR 5597.

Background

CR 5597 modifies Medicare Contractor Beneficiary and Provider Communications Manual, Publication 100-09. These changes are summarized as follows:

Overlapping Claims - New Rules

Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.

When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.

Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.

For specific information regarding the resolution of claims rejected by Medicare's Common Working File (CWF) system, refer to the Medicare Claims Processing Manual, Chapter 27, §50 at <http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf>.

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Information Available on the IVR

- USE THE IVR whenever possible. Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

Information Available on the Remittance Advice (RA)

- USE THE RA whenever possible. If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* which is available at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf.
- Also available is a website that serves as a resource allowing providers to check the definitions of Claim Adjustment Reason Codes and Remittance Advice Remark Codes. This information is available at <http://www.wpc-edi.com/products/codelists/alertservice> on the Washington Publishing Company Web site.
- There is a Web-based training course, *Understanding the Remittance Advice for Professional Providers*, which is available at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

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Authentication of Beneficiary Elements: additions to current rules.

CR 5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR 5597 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf>.

Additional Key Points of CR 5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, you must notify the contractor before the event.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf>.

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

Deceased Providers: Provider Education for Handling Related Issues

This article was revised on June 28, 2007, to delete one sentence that should not have been in the article. On May 7, 2007, a statement was added that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM 5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

Provider Types Affected

Those submitting claims on behalf of physicians and providers who died before obtaining a National Provider Identifier (NPI), where such submitted claims that were received by a Medicare contractor after May 23, 2007.

Background

This article and related Change Request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used.

All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

- Any health care provider who is an entity covered under HIPAA must obtain an NPI.
- Health care providers meeting the definition of health care provider referenced in the NPI final rule but not covered entities are eligible to obtain NPIs as well.
- Health care providers covered under HIPAA must use NPIs to identify themselves and their subparts (if applicable) on all standard transactions adopted under HIPAA.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

Key Points of CR 5508

If an individual provider dies before obtaining an NPI, the following apply:

- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and **Medicare (the Medicare contractor, the Medicare Online Survey and Certification Reporting System (OSCAR), of the National Supplier Clearinghouse (NSC)) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider's NPI.**

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- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. Toll free numbers of the Medicare contractors are available at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.
- The State in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some States send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:
- Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
- A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

Additional Information

You may view the official instruction (CR 5508) by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf>.

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

Vaccines and Vaccine Administration Under Medicare Part D: Reimbursement

Provider Action Needed

This Special Edition *MLN Matters* article describes the Centers for Medicare & Medicaid Services (CMS) policy regarding provider reimbursement for Part D vaccines and vaccine administration in 2007 and 2008 under the Medicare Prescription Drug Benefit (Part D). In addition, the article outlines various approaches that Part D plans may implement to ensure beneficiaries have adequate access to Part D vaccines.

Background

With the advent of the Medicare Part D program, there is now broader reimbursement available to providers for vaccines administered to Medicare beneficiaries. Some vaccines are covered under Medicare Part B and others under Part D. The Part B program covers most of the vaccines indicated for the Medicare population, with the immunizer administering the vaccine and billing the Part B contractor (Medicare carrier or Part A/B Medicare Administrative Contractor or A/B MAC) for both the vaccine and its associated administration. The Part D program generally covers those vaccines not available under Part B; however, unlike Part B, the immunizer may or may not be able to directly bill the Part D Sponsor for the vaccine and its administration, but instead may need to work with the beneficiary and his/her Part D plan to facilitate reimbursement. The first step is for the provider to understand which vaccines are available under the two different programs so he/she can assist the beneficiary in obtaining the vaccines needed to maintain and improve his/her health.

Coverage of Vaccines Under the Part B Program

Medicare Part B currently covers the following immunizations:

- Pneumococcal pneumonia vaccine;
- Influenza virus vaccine;
- Hepatitis B vaccine for individuals at high or intermediate risk; and

Other vaccines (e.g. tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

If a vaccine is covered under Part B, it will continue to be covered under Part B regardless of the changes to Part D vaccine administration reimbursement in 2007 and 2008 discussed later in this article.

Coverage of Vaccines under the Part D Program

The Part D program will generally cover those vaccines not available for reimbursement under Medicare Parts A or B when administration is reasonable and necessary for the prevention of illness.

Part D plans identify covered drugs and vaccines through the use of formularies. However, a new preventative vaccine may not be specifically listed on the Part D plan's formulary. This does not mean the vaccine is not available for reimbursement. The provider can contact the Part D plan about coverage and any supporting

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information that might be necessary to facilitate vaccine coverage for the beneficiary (Part D plan contact information is located at the end of this article).

To facilitate greater access to Part D vaccines, CMS has directed that starting in 2008 all Part D plans' formularies must contain all commercially available vaccines (unless excluded due to available reimbursement under Part B, e.g., influenza or pneumococcal vaccines as discussed above).

Example of identifying vaccines covered under Part B or Part D

Hepatitis B vaccine provides a useful illustration of how a provider could approach vaccine reimbursement under Medicare Part B or D. **Part B covers Hepatitis B vaccine for intermediate and high risk patients.** A beneficiary meeting the intermediate or high risk coverage criteria could obtain the Hepatitis B vaccination series from their physician and the physician would submit a claim to the Medicare Part B contractor. For the beneficiary who did not satisfy the appropriate Part B risk criteria, he or she could still obtain the Hepatitis B vaccine from their physician; however, any potential reimbursement would be available from the beneficiary's Part D plan instead of the Part B contractor. Facilitation of Part D vaccine reimbursement is discussed later in this article.

Coverage of Vaccine Administration Under the Part B Program

The Tax Relief and Health Care Act (TRHCA), effective January 1, 2007, provided for reimbursement of vaccine administration associated with Part D vaccines. Pharmacies and physicians can use a newly instituted G HCPCS code (G0377) to bill Part D vaccine administration to local Medicare Part B contractors. Normal Part B beneficiary deductible and coinsurance requirements apply and **reimbursement for this code is only effective for calendar year 2007.**

Payment for the actual Part D covered vaccine is the responsibility of the beneficiary's Part D plan. In other words, in 2007 Medicare Part B will not pay for the Part D vaccine (i.e. low risk Hepatitis B vaccine), just the Part D vaccine administration.

For additional information on Part B reimbursement of Part D vaccine administration in 2007 see the *MLN Matters* articles MM 5443 and MM 5459, published in December, 2006:

- MM 5443 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf> and
- MM 5459 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf>.

Coverage of Vaccine Administration Under the Part D Program

TRHCA modified the definition of a Part D drug to include "for [Part D] vaccines administered on or after January 1, 2008, **its administration.**" Consequently, beginning on January 1, 2008, the Part D program will cover vaccine administration costs associated with Part D vaccines. **Thus, the coverage available in 2007 under Part B will cease and reimbursement will be available solely under Part D.** CMS interprets this new statutory requirement to mean that the Part D vaccine administration costs are a component of the negotiated price for a Part D-covered vaccine. In other words, the negotiated price for a Part D vaccine will

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be comprised of the vaccine ingredient cost, a dispensing fee (if applicable), sales tax (if applicable) and a vaccine administration fee. This interpretation recognizes the intrinsic linkage that exists between the vaccine and its corresponding administration, since a beneficiary would never purchase a vaccine without the expectation that it would be administered.

In general, CMS believes that Part D vaccines, including the associated administration costs, should be billed on one claim for both in- and out-of-network situations. For example, if an in-network pharmacy dispenses and administers the vaccine in accordance with State law, the pharmacy would process a single claim to the Part D sponsor and collect from the enrollee any applicable cost-sharing on the vaccine and its administration. Alternatively, if a vaccine is administered out-of-network in a physician's office, the physician would administer the vaccine and then bill the beneficiary for the entire charge, including both components. The beneficiary would, in turn, submit a paper claim to the Part D sponsor for reimbursement of plan allowable costs for both the vaccine cost and the administration fee.

Cost-Sharing Considerations

In general, a Part D plan should not charge separate copays for the vaccine and its administration since CMS views the vaccine and its administration as intrinsically linked. If a Part D plan charges coinsurance, it should be applied relative to the entire price of both components. Low income subsidy eligible individuals with copays set by statute (see section 1860D-14(a)(1)(D) of the Social Security Act) will always pay only one copay for a vaccine and all related charges. Thus, for example, a low income subsidy eligible individual entitled to \$1.05/\$3.10 copays in 2008 would pay only \$3.10 for both the vaccine and its administration (and any applicable dispensing fee) even if the components are billed separately.

Elements of Vaccine Administration

CMS expects that Part D plans will take into consideration the elements reflected in existing 2007 Part B vaccine administration fees when establishing their own vaccine administration fees for 2008. Part D plans will have the discretion to implement either a single vaccine administration fee for all vaccines or multiple administration fees based on type of vaccine, variance in provider type, and product administration complexity. Providers should contact Part D plans regarding specific vaccine administration fees for 2008. (Part D plan contact information is listed at the end of this article.)

Part D Reimbursement for Vaccines in Provider Settings

As stated earlier, Part D plans are required to provide access to vaccines not covered under Parts A or B. During initial Part D rulemaking, CMS described use of standard out-of-network requirements to ensure adequate access to the small number of vaccines covered under Part D that are administered in a physician's office. CMS' approach was based on the fact that most vaccines of interest for the Medicare Population (influenza, pneumococcal, and hepatitis B for intermediate and high risk patients) were covered and remain covered under Part B. For those that are not covered under Part B, the beneficiary would pay the physician and then submit a paper claim to his or her Part D plan for reimbursement up to the plan's allowable charge. In the absence of communication with the plan prior to vaccine administration, the amount the physician

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charges may be different from the plan's allowable charge, and a differential may remain that the beneficiary will be responsible for paying.

As newer vaccines have entered the market with indications for use in the Medicare population, Part D vaccine in-network access has become more imperative. Requiring the beneficiary to pay the physician's full charge for a vaccine out of pocket first and be reimbursed by the plan later is not an optimal solution, and CMS has urged Part D plans to implement cost-effective, real-time billing options at the time of administration. CMS issued guidance to Part D plans to investigate alternative approaches to improve access to vaccines under the Drug Benefit without requiring up-front beneficiary payment and to ensure adequate access to Part D vaccines.

CMS outlined the following options to Part D plans for their consideration. Physicians should expect to see various models develop and should be aware of both their potential existence and use by Medicare beneficiaries.

Options to Ensure Adequate Access under Part D to Covered Vaccines

In-Network Distribution Approaches

In-Network Access to Retail Pharmacies: Enrollees could obtain a prescription from the physician and bring it to their local network retail pharmacy for filling. In some states, it will already be possible for the vaccine to be administered by the pharmacist. Forty-six states currently allow pharmacists to provide some type of vaccinations. When it is safe to dispense and administer these vaccines in the pharmacy, plans will be exploring utilization of their network pharmacists as a provider of adult Medicare Part D vaccines.

In-Network Pharmacy Distribution: A Part D plan's local pharmacy or specialty pharmacy could provide vaccines directly to physician offices. Under this scenario, the physician could call in a prescription, or the beneficiary could deliver or mail a prescription for the vaccine to the pharmacy. The pharmacy would fill the prescription for the vaccine, ship or deliver to the physician's office, and bill the Part D plan for the vaccine. (This model resembles the competitive acquisition program (CAP) for Medicare Part B drugs in that the drug is shipped to the physician, but the physician never purchases or gets reimbursed for the drug.)

Out-of-Network Approaches: Facilitated Out-of-Network Access Approaches

Web-Assisted Out-of-Network Billing: Under this approach, physicians would electronically submit beneficiary out-of-network claims to Part D plans for vaccines dispensed and administered in the physician's office through a web-assisted portal (vendor). This approach would allow the beneficiary to pay out of pocket only the appropriate deductible and copay or cost sharing directly to the physician, thus avoiding any up-front payment and repayment for the full cost of the vaccine. The physician would assume responsibility for submitting the claim on behalf of the beneficiary and would agree to accept Part D plan payment as payment in full.

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Model Vaccine Notice for Physicians (Paper Claim Enhancement): Part D plans would provide all enrollees with a vaccine-specific notice that the enrollees could bring to their physicians. This notice would provide information necessary for a physician to contact the enrollee's Part D plan to receive authorization of coverage for a particular vaccine, reimbursement rates, enrollee cost-sharing to be collected by the physician, and instructions on how to submit the out-of-network claim on the beneficiary's behalf.

It is important to emphasize for either out-of-network approach, the physician does not become a network provider, but is assisting the beneficiary in the submission of his or her out-of-network claim.

CMS is working with Part D Sponsors to facilitate these various approaches. CMS encourages additional exploration of other possible means to coordinate the billing of vaccines in the real-time environment of the Part D benefit. CMS expects significant development in this area over the next year.

Frequently Asked Questions

If I need to immunize a beneficiary with a Part D vaccine, what do I need to do?

The beneficiary or physician can call the Part D Plan to discuss what the cost sharing and allowable charges would be for the vaccine as part of the Part D plan's out-of-network access or inquire as to the availability of any alternative vaccine access options. Plan contact information is available at the following Web site: <http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp> and then follow the directions on the section **Learn More About Plans in Your Area**. You may also obtain plan contact information by calling 1-800-MEDICARE.

Do I need to provide Advance Beneficiary Notice (ABN)?

No. Unlike traditional Medicare, Part D does not require ABNs.

Can I charge an administration fee?

Yes. Administration fees for vaccines could be handled in the following manner:

- Before January 1, 2008: When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 (linked to CPT code 90471) to bill the Part B local carrier for the administration fee of the vaccine.
- January 1, 2008 and after: Part D vaccines, including the associated administration costs could be billed on one claim to the beneficiary or to the Part D plan, as stated in the preceding examples.

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Is the Herpes zoster vaccine (Trade name Zostavax) covered under Medicare Part B or D?

Since the Herpes zoster vaccine is a preventive vaccine, it will be available for reimbursement under Part D. Beneficiaries and providers should contact the Part D plans for more information about costs and reimbursement for this and other preventive vaccines.

Additional Information

More information about Part D for physicians is available on the CMS prescription drug Web page for physicians, which is at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp#TopOfPage.

EDI Migration to the GPNet Front End

Effective April 2, 2007 to August 1, 2007, Palmetto GBA (OH/WV) will be transitioning from the current RS6000 front end to GPNet, which is located in our corporate office in South Carolina. All electronic submitters must migrate electronic claim submissions from the current RS6000 to the GPNet front end. As of August 1, all electronic claims must be submitted through the GPNet front end. If this migration is not completed prior to August 1, claims submitted through the RS6000 will not be processed.

Although Ohio and West Virginia claims will be submitted through South Carolina, phone support will continue to be provided by the Electronic Data Interchange (EDI) Technical Support team in Ohio. For all EDI users, activities impacted by the transition include: submission of electronic claims, receipt of electronic remittances, receipt of electronic reports, and access to claim status. Our goal is to make the transition of your EDI activities as simple as possible, with minimal disruption to your billing processes.

Advantages of using GPNet are:

- Immediate response on rejected claims and reports
- Additional edits that may reduce the number of denials on remittance
- Reports will be more explicit and easier to read than current reports
- Easier login
- Technical support will remain the same
- 997 Functional Acknowledgement will be available immediately

Important information to know about GPNet submissions is:

- The appropriate payer ID in the ISA08 must be used. The payer ID for an Ohio provider is 00883 and for West Virginia is 00884. Separate files must be created for Ohio and West Virginia providers or multiple ISA segments may be sent within one file.
- GPNet will not allow transmissions with multiple GS segments; however, multiple ISA's are permitted.
- The only acceptable ID qualifier in the ISA05 and ISA07 is 27.
- There can only be one receiver of electronic remittance for each provider number. A provider may not have multiple remittance arrangements.

If you have questions regarding your transition to the GPNet front end, please contact our Technical Support Center toll-free at 1-866-308-5438.

National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), and Update of Telecommunication and Transmission Protocols for EDI

Impact to You

If not already enrolled for use of electronic billing & other electronic data interchange (EDI) transactions, you will not be able to enroll to begin use if you have not yet obtained a National Provider Identifier (NPI).

What You Need to Know

CR 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI. Your Medicare contractor will not issue you an EDI access number and password until you obtain an NPI.

What You Need to Do

If you have not already obtained your NPI, you should apply now. You can apply on line by going to <https://nppes.cms.hhs.gov/>.

Background

Since May 2006, providers have been required to obtain a National Provider Identifier (NPI) prior to initial Medicare enrollment, or before updating their enrollment records, but were not required to have an NPI, as a condition for enrollment, in order to begin using electronic data interchange (EDI) transactions.

CR 5637, from which this article is taken, announces that (effective October 1, 2007) providers will need to obtain an NPI, as a condition for initial enrollment, for the use of EDI.

This is being implemented to further support efforts by the Centers for Medicare & Medicaid Services (CMS) to have all providers obtain NPIs as soon as possible. Moreover, as indicated in *MLN Matters* article MM 5595 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>), Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

CR 5637 also updates EDI connectivity information in the *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols) because some of the information in the manual is obsolete due to technology changes.

In summary, these changes are:

- Medicare contractors will use V.90 56K modems for EDI transactions submitted via dial-in connections;

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- Medicare contractors will offer data compression in a means that an EDI transaction sender/receiver requests, using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression;
- DME MACs will reject standard National Council for Prescription Drug Programs (NCPDP) transactions that do not use the standard NCPDP electronic envelope;
- Medicare contractors may, but are not required to, accommodate other types of data compression that an EDI submitter/receiver requests.

Additional Information

You can find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf>. As an attachment to CR 5637, you will find updated *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS Web site at <http://www.cms.hhs.gov/ElectronicBillingEDITrans/>, and more information about the NPI at the “National Provider Identifier (NPI) – Time is Running Out!” link on the Main CMS Web site (<http://www.cms.hhs.gov/NationalProviderstand/>).

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

National Plan and Provider Enumeration System (NPES) Errors: Using the NPI on Medicare Claims & 835 Remittance Advice Changes

Impact to You

Certain information you enter into the National Plan and Provider Enumeration System (NPES) in order to obtain and maintain your National Provider Identifier (NPI) is used by Medicare in processing claims.

What You Need to Know

If the information you entered in NPES is not correct, your claims may reject. It is important to verify that information was entered correctly. Other guidance in this article will also help assure your claims are processed timely and correctly.

What You Need to Do

The Centers for Medicare & Medicaid Services (CMS) recommends that physicians, providers, and suppliers validate their NPES data and be sure their staff are aware of the key elements that need to be correct as explained in this article. Also, you may want to be sure your staff are aware of the important billing tips in this article.

Background

As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

Common Enumeration Errors in NPES

Below are some of the more frequent errors providers have been making when applying for NPIs:

- **Errors in Employer Identification Number (EIN):** As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the Taxpayer Identification Number (TIN). With the revised NPI Application/Update Form (CMS-10114) (to be used beginning July 10, 2007, for on-line, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their “parent” and the “parent’s” TIN. The applicant will continue to be required to report its EIN. **If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.**
- **Invalid or incomplete data within the ‘Other Provider Identifiers’ section of the NPES online application, such as:**
 - The absence of the Medicare legacy number,
 - Not having the ‘Type’ listed as Medicare for a Medicare provider number, and/or

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- Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.
- **Reporting an Incomplete Identifier:** Medicare providers/suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPPES, they report the full identifier. This means that suffixes to the OSCAR/Certification Numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPPES data and the NPI crosswalk.
- **Having More than the Allowable Number of Legacy Numbers:** At the present time, the NPPES can capture a grand total of 20 “Other Provider Identification Numbers.” While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPPES will be expanded to capture more than 20 “Other Provider Identification Numbers” at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.
- **Listing Legacy Numbers that Do Not Belong to the Applicant:** The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/Certification Number, Provider Identification Number (PIN), Unique Physician Identification Number (UPIN), and National Supplier Clearinghouse (NSC) Number) entered in that field in NPPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the “Other Provider Identification Numbers” section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the “Do’s and Don’ts” section below.

Dos and Don’ts When Reporting “Other Provider Identification Numbers” in NPPES

- **For a Medicare physician or other practitioner applying for an NPI:** DO include your UPIN (if one was assigned) and your PIN when applying for an NPI. DO NOT include the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.
- **For a Medicare group practice or clinic applying for an NPI:** DO include your PIN. DO NOT include the PINs or UPINs of any of the members of the group practice or clinic.
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier:** DO include both NSC Numbers (pharmacy and DME supplier).
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy:** DO include the NSC number assigned to the pharmacy, but DO NOT include the NSC number assigned to the DME supplier.

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- **For a Medicare pharmacy that is applying for an NPI as a DME supplier:** DO include the NSC Number assigned to the DME supplier. DO NOT include the NSC Number assigned to the pharmacy.
- **For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit:** DO include the OSCAR/Certification Number assigned to the swing bed unit. DO NOT include the OSCAR/Certification Number assigned to the hospital.
- **For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs:** DO include the OSCAR/Certification number assigned to the hospital and the OSCAR/Certification Numbers assigned to both the swing bed unit and the rehabilitation unit.

If Medicare providers/suppliers determine that they should make changes to their NPPES records, they may do so by going to NPPES at <https://nppes.cms.hhs.gov/> at any time and updating their information. Or, if they prefer, they may send updates on the paper NPI Application/Update Form (CMS-10114). Forms may be requested by calling the NPI Enumerator at their toll-free number, which is 1-800-465-3203, TTY 1-800-692-2326. The revised CMS-10114 is to be used beginning July 10, 2007. These forms can be obtained from the Enumerator, as outlined above, or you may download the form from the CMS Forms page at <http://www.cms.hhs.gov/cmsforms>.

CMS recommends that Medicare providers/suppliers make a copy of their NPPES information by doing a “print screen” of their NPPES record or make a photocopy of the completed paper NPI Application/Update form and keep it on hand for reference if they encounter problems.

Common Error in Reporting Change of Ownership to Medicare

Delays in reporting Change of Ownership: Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

How to Use Your NPI When Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC

For providers who submit electronic Part A institutional claims to Medicare FIs or A/B MACs, a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Failure to properly submit the NPI in the correct loops may cause the claim to reject. Organization providers should utilize their NPI in the 2010AA or 2010AB loop. The attending, operating or other physicians should be identified in the 2310A, B and C loops respectively. If 2420A loop is used, the Attending Physician NPI must be submitted.

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Below is a guide to use when submitting primary NPI's:

Name/Loop	Legacy Information	NPI Information
Billing Provider 2010AA Loop	OSCAR	Provider NPI
Pay to Provider 2010AB Loop	OSCAR	Provider NPI
Attending Physician 2310A Loop	PIN, UPIN	Physician NPI
Operating Physician 2310B Loop	PIN, UPIN	Physician NPI
Other Physician 2310C	PIN, UPIN	Physician NPI
Attending Physician 2420A	PIN, UPIN	Physician NPI

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk.

If a reject or RTP (Return to Provider) is received, **providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at <https://nppes.cms.hhs.gov/>.**

The following is a listing of Front-end Processing Reason Codes:

Code	Description
32000	This claim has been rejected because the intermediary has no record of the Medicare provider number submitted.
32102	The claim contains an NPI but the first digit of the NPI is not equal to “1”, “2”, “3”, “4” or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct. **Online providers – press PF9 to store the claim. **Other providers – return to the intermediary.

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Code	Description
32103	<p>NPI/OSCAR pair on the claim is not present in the Medicare NPI Crosswalk File.</p> <p>This edit applies to the NPI associated with the OSCAR number. Please verify provider billing number and, if appropriate, please correct either NPPES or your CMS-855 information.</p> <p>Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/correct your NPPES information by going to https://nppes.cms.hhs.gov.</p> <p>If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARs) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e. – the CMS 855). Please contact your contractor prior to submitting a CMS-855 form.</p>
32104	<p>The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the Crosswalk File, but the associated legacy (OSCAR) number in the Crosswalk file does not match the legacy (OSCAR) number on the claim. Please verify billing number and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other Providers – Return to the intermediary.</p>
32105	<p>The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number.</p> <p>Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>
32107	<p>The NPI for the attending physician on the claim is not present in the Crosswalk File.</p> <p>Please verify billing number and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>

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Code	Description
32108	<p>The attending physician's NPI and UPIN are present on the claim and the attending physician's NPI is present in the Crosswalk File, but the attending physician's UPIN in the Crosswalk File does not match the attending physician's UPIN on the claim.</p> <p>Please verify the UPIN and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>
32109	<p>The operating physician's NPI on the claim is not present in the Crosswalk File.</p> <p>Please verify billing number and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>
32110	<p>The operating physician's NPI and UPIN are present on the claim and the operating physician's NPI is present in the Crosswalk File, but the operating physician's UPIN in the Crosswalk File does not match the operating physician's UPIN on the claim.</p> <p>Please verify the UPIN and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>
32111	<p>The other physician NPI on the claim is not present in the Crosswalk File.</p> <p>Please verify the billing number and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>
32112	<p>The other physician's NPI and UPIN are present on the claim and the other physician's NPI is present in the Crosswalk File, but the other physician's UPIN in the Crosswalk File does not match the other physician's UPIN on the claim.</p> <p>Please verify the UPIN and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>

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Code	Description
32113	<p>The taxonomy code entered is invalid.</p> <p>Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number.</p> <p>Please verify the billing number and, if appropriate, correct.</p> <p>***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.</p>

If your FI or A/B MAC is using the MEDATRAN claims translator, below is a list of EDI Inbound Reject codes you may receive:

Edit Number	Loop	Edit Description
99	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
99	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
99	2310A,B,C	The NPI/Legacy combination does not match the NPI crosswalk.
99	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

How to Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs

For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

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Below is a guide to use when submitting primary NPI's:

Name/Loop	Legacy Information	NPI Information
Billing Provider 2010AA Loop	Group PIN Individual PIN	Group NPI Individual NPI
Pay to Provider 2010AB Loop (this should only be submitted if different from Billing Provider)	Group PIN Individual PIN	Group NPI Individual NPI
Rendering Provider 2310B Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual / Member of Group NPI
Rendering Provider 2420A Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual / Member of Group NPI

Some carriers and A/B MACs will return the informational messages or edits below when the NPI and legacy identifier combination submitted does not match the NPI crosswalk. As of the date of this article, claims with NPI/legacy identifiers are not rejecting because Part B contractors (except CIGNA Tennessee and Idaho), have “crosswalk bypass” logic in their system that will allow invalid pairs to process on the legacy number. The informational edits you are receiving are a warning that your claims will reject when the logic is removed. Providers are encouraged to verify that the NPI/legacy identifier combination is valid on NPES at <https://nppes.cms.hhs.gov> prior to submission of Medicare claims.

Following is a listing of the edits you may receive when billing Professional Part B claims:

Edit Number	Loop	Edit Description
M340	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
M341	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
M343	2310B	The NPI/Legacy combination does not match the NPI crosswalk.
M347	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

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Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting Claims to DME MACS Only.

DME suppliers are reminded that important changes will occur on your electronic remittance advice and your standard paper remittance actions, effective July 2, 2007. As of that date when you have submitted an NPI on your claim, your DME MAC will report on the 835 (or via the Medicare Remit Easy Print (MREP) Software) as follows:

- The billing/pay-to NPI will be reported at the Payee level (Loop 1000B in N104 with the XX qualifier in N103 of the 835),
- The TIN (EIN/SSN) will be reported in the REF segment (Loop 1000B, data field REF 02 with qualifier TJ in REF 01 of the 835) as Payee Additional ID,
- Any relevant Rendering Provider NPI will be reported at the claim level (Loop 2100, data field NM 109 with qualifier XX in NM 108 on the 835) if different from the Payee NPI, and
- Any relevant Rendering NPI(s) will be reported at the service line level (Loop 2110, data field REF 02 with qualifier HPI in REF 01 on the 835) when different from the claim level Rendering NPI.

When you do not report your NPI, but report your legacy National Supplier Clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR 5452, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf> or in the related *MLN Matters* article, MM 5452, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

Important NOTE: The 835 Remittance Advice changes listed above will be effective for other providers submitting Part A Institutional claims and Part B Professional claims, at a later date. Medicare will notify submitters when a date is determined.

Additional Information

You may also want to review *MLN Matters* article SE 0679, which has additional information on the overall NPI activity. This article is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf>. Important information regarding current NPI implementation contingency plan is in article MM 5595, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

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

Skilled Nursing Facility Consolidated Billing: Common Working File

What Providers Need to Know

Effective for dates of service on or after April 1, 2001, CR 5624, from which this article is taken, instructs Medicare carriers, A/B MACs, and DME MACs to bypass certain current SNF consolidated billing (CB) Part B and Part B/DMEMAC edits in order to enable the identification of periods when SNF CB edits should not be applied.

Background

CR 5624 instructs Medicare carriers, A/B MACs, and DME MACs (effective April 1, 2001) to bypass SNF CB Part B and Part B/DMEMAC edits when certain inpatient claims are present on Medicare's history.

These revisions will allow Medicare SNF CB editing to take into account periods of SNF stays that are non-covered by Medicare Part A when services should be payable outside of CB by the Medicare Part B contractor.

Note: *CR 5624 does not change the policy for SNF CB. It adjusts Medicare's claims systems to be in line with current policy.*

Medicare contractors (carrier, A/B MAC, or DME MAC) will re-open and re-process inappropriately denied claims for dates of service on or after April 1, 2001 through January 1, 2008 when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. The change will be implemented on January 7, 2008 and claims will be processed correctly as of that date.

Additional Information

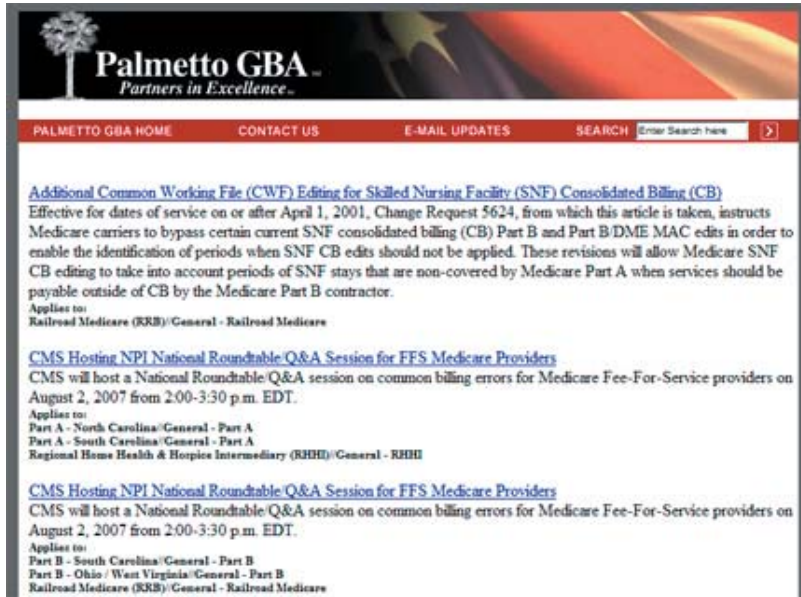
You can find the official instruction, CR 5624, issued to your carrier, A/B MAC, or DME MAC on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1289CP.pdf>. As an attachment to CR 5624, you will find updated *Medicare Claims Processing Manual* (100-04), Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits), 110.2.4 (Edit for Ambulance Services), and 110.2.5 (Edit for Clinical Social Workers (CSWs)).

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

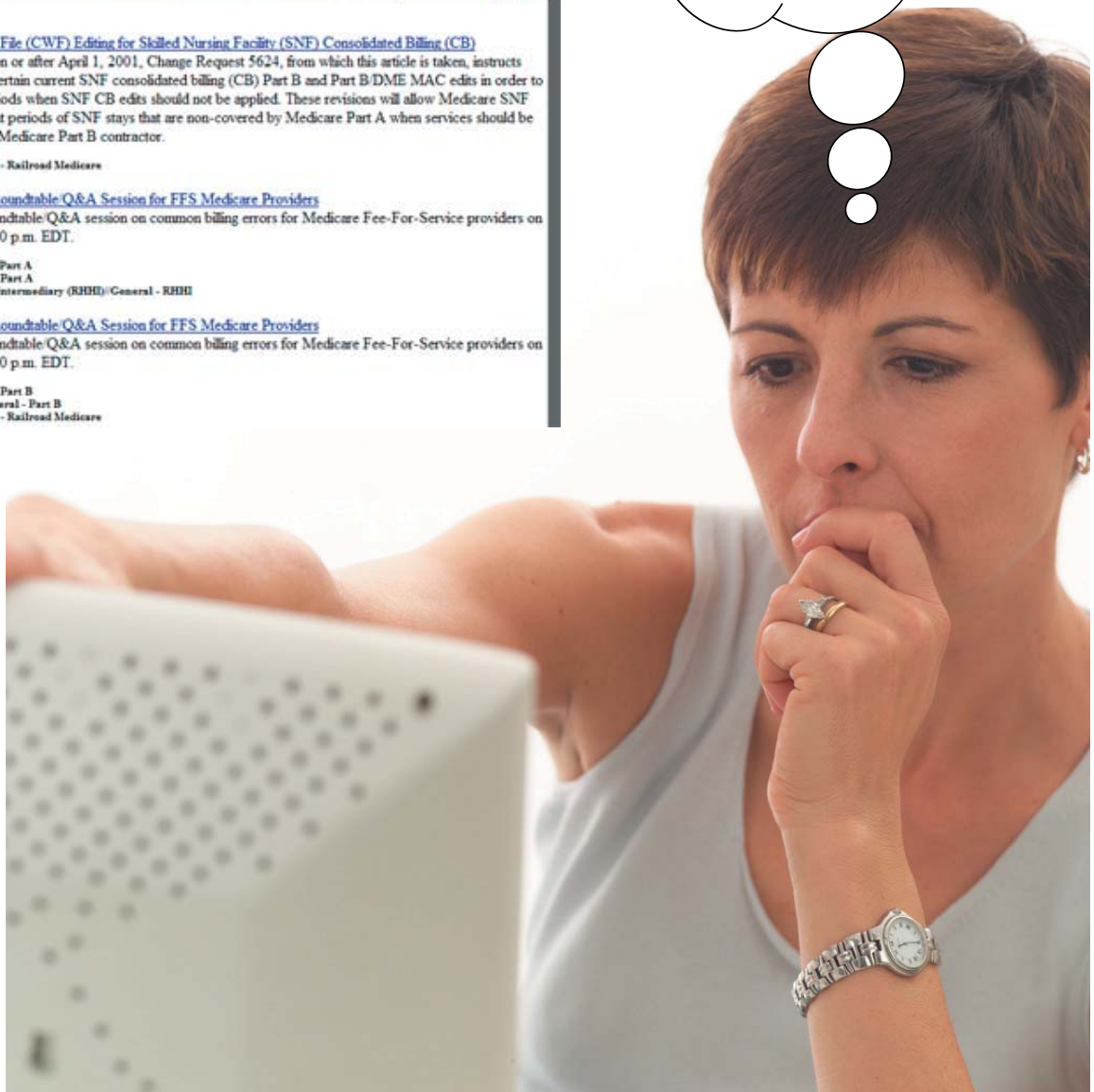
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Palmetto Place

Don't delay....sign up today.



Wow! These Email Updates that I receive from Palmetto GBA are so helpful. It keeps me up-to-date on the latest Medicare Part B changes and saves me time. It has made my job so much easier...I will have my co-workers register also to make their jobs easier.



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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 Data Interchange (EDI)	Organ Procurement	
Federally Qualified Health Center	Pathology & Laboratory	

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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, 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, 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.

Average Sales Price (ASP) Medicare Part B Drug Pricing File: July 2007 Update

Provider Action Needed

This article is based on Change Request (CR) 5646 which informs Medicare providers of the availability of the July 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 and April 2007 ASP files. Providers should make certain that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Web site at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>.

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, CMS reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” are operationalized in the context of payment under section 1847A. For the purposes of identifying “single source drugs” and “biological products” subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate

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payment may also be operationalized through use of existing specific HCPCS codes or “not otherwise classified” HCPCS codes.

For 2007, a separate fee of \$0.152 per International Unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.

The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.

The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when

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the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 19, 2007, revised January 2007 and April 2007 ASP payment files and the July 2007 ASP file will be available for retrieval from the CMS ASP Web page. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP Web page is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2007	July 1, 2007 through September 30, 2007
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007

NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in

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order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

The official instruction (CR 5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf>.

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

Medicare Physician Fee Schedule Database (MPFSDB) 2007 Update

Note: This article was changed on July 9, 2007, to reference MM 5635. MM 5635 implemented HCPCS coding changes for Immune Globulin. **On or after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare.** There is a reference to HCPCS code J1567 on page 3 of this article. To view the new HCPCS codes for Immune Globulin, please go to <http://www.cms.hhs.gov/MLN MattersArticles/downloads/mm5635.pdf> on the CMS Web site.

Impact to You

Payment files for the MPFS were issued based on the December 1, 2006 Medicare Physician Fee Schedule Final Rule. CR 5614, amends those files and includes new/revised codes for the Physician Quality Reporting Initiative (PQRI)

What You Need to Know

Physicians and providers may want to pay particular attention to **Attachment 1** of CR 5614 that identifies the changes included in the July Update to the 2007 MPFSDB-the **highlights of attachment 1 are:**

- Effective for dates of service on or after July 1, 2007 Category II CPT modifier 8P will be recognized in addition to Category II CPT modifiers 1P, 2P and 3P. (Note: CPT modifier 8P is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure’s numerator is not performed and the reason is not otherwise specified.)
- Effective for dates of service on or after January 1, 2007, Medicare contractors will update their systems to reflect 11 base units for CPT code 00797.
- This CR 5614 lists the new Category II HCPCS codes that will be added to the MPFSDB with a status indicator of “M” for the PQRI.

What You Need to Do

Make certain that your billing staffs are aware of these changes.

Background

Section 1848 (c)(4) of the Social Security Act provides for the establishment of the policies needed in order to implement relative values for physicians’ services. CR 5614 is the official document that announces these changes in the Medicare schedule. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services (CMS) directs you to **CR 5614, which contains lengthy lists of these items.** CR 5614 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf>.

As mentioned above, the key portion of CR 5614 is Attachment 1, which includes the following information:

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- Several changes retroactive to January 1, 2007. The changes are for the following:
 - CPT codes:
 - 00797 (base units set to 11);
 - 0115T, 0116T, and 0117T (procedure status is now N);
 - 19301 (short descriptor is Partial mastectomy);
 - 33208 (work RVUs set to 8.72);
 - 75365 with HCPCS modifier TC (diagnostic indicator set to 02); and
 - 77422, 77423 (PE RVU changes).
 - HCPCS codes:
 - G9041, G9042, G9043, G9044 (PE RVU changes).
- CPT codes 0024T and 0133T are assigned a procedure status of I effective for dates of service on or after July 1, 2007.
- As previously mentioned, CPT modifier 8P is added for the PQRI program.
- The list of G HCPCS codes that are no longer used for the PQRI program as of July 1, 2007.
- The list of new CPT Category II codes, new G HCPCS codes and the new/revised descriptors for the codes that will be used for the PQRI, effective for dates of service on or after July 1, 2007.
- Information on Category III CPT codes (0178T through 0180T (all of which deal with electrocardiograms), 0181T (corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report), and 0182T (High dose rate_ electronic brachytherapy, per fraction), which are effective for dates of service on or after July 1, 2007.
- Effective July 1, 2007, HCPCS codes J1567, J7611, J7612, J7613, and J7614 will be assigned a procedure status of I. **(See note above regarding HCPCS code J1567.)**
- Information related to HCPCS codes Q4087 through Q4095, which are added to the MPFSDB as of July 1, 2007 with a status indicator of E.

Also, attachment 3 (which is informational only) states that the Performance Payment Indicator has been changed to ‘1’ for the extensive list of carrier priced codes identified in attachment 3.

Effective January 1, 2007, for services performed on or after July 2, 2007, the Centers for Medicare and Medicaid Services (CMS) have made changes to the following HCPCS and CPT codes on the 2007 Medicare Physician Fee Schedule Database (MPFSDB).

The following are revisions to the current MPFSDB:

HCPCS Code	State	NON-FACILITY SETTING			FACILITY SETTING		
		PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
G9041	OH	\$25.79	\$24.50	\$28.18	\$25.79	\$24.50	\$28.18
	WV	\$24.75	\$23.51	\$27.04	\$24.75	\$23.51	\$27.04

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HCPCS Code	State	NON-FACILITY SETTING			FACILITY SETTING		
		PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
G9042	OH	\$14.04	\$13.34	\$15.34	\$14.04	\$13.34	\$15.34
	WV	\$13.00	\$12.35	\$14.20	\$13.00	\$12.35	\$14.20
G9043	OH	\$14.04	\$13.34	\$15.34	\$14.04	\$13.34	\$15.34
	WV	\$13.00	\$12.35	\$14.20	\$13.00	\$12.35	\$14.20
G9044	OH	\$11.92	\$11.32	\$13.02	\$11.92	\$11.32	\$13.02
	WV	\$11.14	\$10.58	\$12.17	\$11.14	\$10.58	\$12.17

CPT Code	State	NON-FACILITY SETTING			NON-FACILITY SETTING		
		PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
33208	OH	\$492.70	\$468.07	\$538.28	\$492.70	\$468.07	\$538.28
	WV	\$483.24	\$459.08	\$527.94	\$483.24	\$459.08	\$527.94
77422	OH	\$97.11	\$92.25	\$106.09	\$97.11	\$92.25	\$106.09
	WV	\$88.61	\$84.18	\$96.81	\$88.61	\$84.18	\$96.81
77423	OH	\$131.09	\$124.54	\$143.22	\$131.09	\$124.54	\$143.22
	WV	\$118.44	\$112.52	\$129.40	\$118.44	\$112.52	\$129.40

(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).

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5614) 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/R1258CP.pdf>.

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

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Preadministration-Related Services Associated with IVIG Administration - Medicare Payment Extended through CY 2007

Note: This article was changed on July 9, 2007, to reference MM 5635. MM 5635 implemented HCPCS coding changes for Immune Globulin. **On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare.** To view the new HCPCS codes, please go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf>.

Impact to You

You may bill for preadministration-related services associated with Intravenous Immune Globulin (IVIG) administration (HCPCS code G0332) during calendar year 2007. The preadministration-related service must be billed on the same claim and have the same date of service, as the claim for the IVIG itself (HCPCS codes J1566 and/or J1567) and the drug administration service. **(See note above regarding J1567.)**

What You Need to Know

CR 5428, from which this article was taken, extends payment of the preadministration-related service for IVIG through CY 2007 **but only when submitted on the same claim as the IVIG and its administration.**

What You Need to Do

Make sure that your billing staff is aware that they must include your claim for the IVIG preadministration-related services on the same claim (and with the same date of service) as the IVIG and its administration.

Background

Under Section 1861(s)(1) and 1861(s)(2), Medicare Part B covers intravenous immune globulin (IVIG) administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

In addition, for 2006, CMS established a temporary preadministration-related service payment, for physicians and hospital outpatient departments that administer IVIG to Medicare beneficiaries, to cover the effort required to locate and acquire adequate IVIG product and to prepare for an infusion of IVIG during this current period where there may be potential market issues. **CR 5428, from which this article was taken, announces the extension of this temporary payment for the IVIG preadministration-related service through CY 2007.**

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG preadministration-related services payment are the same in 2007 as they were in 2006.

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- This IVIG pre-administration service payment is in addition to Medicare’s payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare Carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332 -Preadministration-Related Services for Intravenous Infusion of Immunoglobulin, (this service is to be billed in conjunction with administration of immunoglobulin) to bill for this service.
- You can bill for this only one IVIG preadministration per patient per day of IVIG administration.
- The service must be billed on the same claim form as the IVIG product (HCPCS codes J1566 (Injection, immune globulin, intravenous, lyophilized (E.G. powder), 500 mg) and/or HCPCS code J1567 (Injection, immune globulin, intravenous, non-lyophilized (E.G. liquid), 500 mg), and have the same date of service as the IVIG product and a drug administration service. **(See note above regarding HCPCS code J1567.)**

Your claims for preadministration-related services will be returned/rejected by your FI, carrier, or A/B MAC if more than 1 unit of service of HCPCS code G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:

- M80-“Not covered when performed during the same session/date as a previously processed service for the patient;”
- B5-“Payment adjusted because coverage/program guidelines were not met or were exceeded;”
- M67-“Missing other procedure codes;” and/or
- 16-“Claim/service lacks information which is needed for adjudication.”

Additional Information

You can find the official instruction, CR 5428, issued to your FI, carrier, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1140CP.pdf>.

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

Influenza Billing: Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 for Part B

Key Points of CR 5511

It is important that providers who want to participate in centralized billing programs understand and follow the rules governing the program. Specifically, approval to participate in the CMS centralized billing program is a two part approval process. Individuals and corporations who wish to enroll as a CMS Mass Immunizer Centralized Biller must send their request to participate as a centralized biller in writing by June 1 of the year they wish to begin centralized billing. These written requests should be sent to the following address:

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

CO will complete Part 1 of the approval process by reviewing preliminary demographic information included in the request for participation letter. **Completion of Part 1 is not approval to set up flu clinics, vaccinate beneficiaries, and bill Medicare for reimbursement.**

All new participants must complete Part 2 of the approval process (Form CMS-855 Application) before they may set up flu clinics, vaccinate Medicare beneficiaries, and bill Medicare for reimbursement. **If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year.** The designated Medicare carrier for centralized billing will provide in writing to CMS CO and to approved centralized billers notification of completion and approval of Part 2 of the approval process. The designated carrier may not process claims for any centralized biller who has not completed Parts 1 and 2 of the approval process. If claims are submitted by a provider who has not received approval of Parts 1 and 2 of the approval process to participate as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

Before September 1 of every year, CMS CO provides the designated carrier with the names of the entities that are authorized to participate in centralized billing for the 12 month period beginning September 1 and ending August 31 of the next year.

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application).

Providers/suppliers are encouraged to apply to enroll as a centralized biller early as the enrollment process takes 8 -12 weeks to complete. Applicants who have not completed the entire enrollment process and

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received approval from CMS CO and the designated carrier to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.

In addition to the centralized billing processes, the following are revised portions of Chapter 18, Section 10, of the *Medicare Claims Processing Manual*, which is attached to CR 5511 (the web address for CR 5511 is provided in the *Additional Information* section of this article):

Chapter 18/Section 10.2.5 - Claims Submitted to Carriers

The administration of the influenza virus vaccine is covered in the flu vaccine benefit under §1861(s)(10)(A) of the Act, rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent Health Professional Shortage Area (HPSA) incentive payment *or the 5 percent Physician Scarcity Area (PSA) incentive payment.*

Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision.

Chapter 18/Section 10.3.1 - Roster Claims Submitted to Carriers for Mass Immunization

If a Public Health Center (PHC) or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 (08-05).

Chapter 18/Section 10.3.1.1 - Centralized Billing for Flu and Pneumococcal (PPV) Vaccines to Medicare Carriers

Format Clarifications for Roster Cover Document

Providers submitting roster claims must complete a cover form CMS-1500 (08-05) and are reminded that:

- Item 32 must be completed to report the name, address, and ZIP code of the location where the service was provided (including centralized billers).
- Item 32a must be completed to report the NPI of the service facility (e.g., hospitals) if it is available. The carrier will use the ZIP code in Item 32 to determine the payment locality for the claim. (The NPI can be reported on the form CMS-1500 (08-05) as of January 1, 2007.)
- Once Medicare requires NPI reporting, the NPI of the billing provider or group must be reported in item 33a. (The NPI can be reported on the form CMS-1500 (08-05) as of January 1, 2007.)

Format Clarifications for Roster Claims

Item 33 must be completed to report the provider of service/supplier's billing name, address, ZIP code, and telephone number. Once Medicare requires NPI submissions, the NPI of the billing provider or group must be reported.

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For electronic claims, the name, address, **and ZIP code** of the facility is reported in:

- The HIPAA compliant ANSI X12N 837: Claim level loop 2310D NM101=FA. When implemented, the facility (e.g., hospital's) NPI will be reported in the loop 2310D NM109 (NM108=XX) if one is available. Prior to NPI, enter the tax information in loop 2310D NM109 (NM108=24 or 34) and enter the Medicare legacy facility identifier in loop 2310D REF02 (REF01=1C). Report the address, city, state, and ZIP code in loop 2310d N301 and N401, N402, and N403. Facility data is not required to be reported at the line level for centralized billing.
- Providers note that if a claim is received with an invalid ZIP code, carriers will return the claims as unprocessable.
- If a claim is received with a ZIP code that is not valid for the street address given, carriers will return the claim as unprocessable.

Chapter 18/Section 10.4.2

In your annual request to participate in centralized billing you must also:

- Include the names and addresses of all entities operating under the corporation's application; and
- Include contact information for a designated contact person for your centralized billing program.

Providers should note that the practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment upfront.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5511) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1278CP.pdf>.

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

Medicare Guide to Colorectal Cancer Screening

Background

- What does “screening” mean?
 - A **screening** test or procedure is one performed in the absence of signs or symptoms.
 - Medicare may cover medically necessary **diagnostic** (non-screening) tests or procedures more frequently than the chart indicates. There are different HCPCS and CPT codes for diagnostic and screening procedures.
- Who is covered for colorectal cancer screening?
 - Medicare beneficiaries age 50 and older.
 - Exception: there is no age restriction on coverage for screening colonoscopy for patients at high risk.
 - Exception: there is no age restriction on coverage for a barium enema as an alternative to colonoscopy for patients at high risk.
- What if a patient wants to have more frequent screening procedures than Medicare covers?
 - You may ask the patient to sign an Advance Beneficiary Notice (ABN) if he or she chooses to have screening procedures performed more frequently than Medicare will cover.
 - The CMS ABN form is available at: <http://www.cms.hhs.gov/BNI/Downloads/CMSR131G.pdf>.
- What are the criteria for “at high risk for colorectal cancer”?
 - 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
 - A personal history of inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis
- The table below is for physician charges only and does not include facility charges. What other charges might there be?
 - The table is based on fees for providers that are “participating” in the Medicare program. There are different payment amounts for services by non-participating physicians, which may result in higher out-of-pocket costs to patients.
 - For services that are performed in an inpatient or outpatient hospital or in an Ambulatory Surgery Center (ASC), both the physician and the facility have separate charges.
 - For some colorectal cancer screening procedures performed in ASCs (place of service 24), there is a 25% patient coinsurance. Services that are subject to the 25% coinsurance for the ASC’s charges are HCPCS codes G0104 (screening flexible sigmoidoscopy), G0105 and G0121 (screening colonoscopy).
- Does the Medicare deductible apply to colorectal cancer screening procedures?
 - For services performed in 2007, the deductible **does** apply to the following HCPCS code: G0328.
 - For services performed in 2007, the deductible **does not** apply to the following HCPCS codes: G0104, G0105, G0106, G0120, and G0121.

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Procedure Code	Description	Ohio Fee Schedule Amount: 2007, Physician Charges		Beneficiary Co-insurance Amount: 2007, Physician Charges		Covered Frequency
		Performed in non-facility setting	Performed in facility setting	Performed in non-facility setting	Performed in facility setting	
HCPCS code G0104	Flexible sigmoidoscopy	\$117.98	\$54.26	\$23.60 (20% of \$117.98)	\$10.85 (20% of \$54.26)	Every 4 years, or once every 10 years after having had a screening colonoscopy
HCPCS code G0105	Screening colonoscopy (high risk)	\$356.19	\$192.31	\$71.24 (20% of \$356.19)	\$38.46 (20% of \$192.31)	Every 24 months
HCPCS code G0121	Screening colonoscopy (not high risk)	\$356.19	\$192.31	\$71.24 (20% of \$356.19)	\$38.46 (20% of \$192.31)	Every 10 years
HCPCS code G0106	Barium enema (alternative to HCPCS code G0104 colonoscopy for patients at high risk)	\$148.58	N/A	\$29.72 (20% of \$148.58)	N/A	Every 24 months
HCPCS code G0120	Barium enema (alternative to HCPCS code G0105 colonoscopy for patients not at high risk)	\$148.58	N/A	\$29.72 (20% of \$148.58)	N/A	Every 4 years
HCPCS code G0122	Barium enema (non-covered)	N/A	N/A	N/A	N/A	N/A

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Procedure Code	Description	Ohio Fee Schedule Amount: 2007, Physician Charges		Beneficiary Co-insurance Amount: 2007, Physician Charges		Covered Frequency
		Performed in non-facility setting	Performed in facility setting	Performed in non-facility setting	Performed in facility setting	
HCPCS code G0328	Fecal Occult Blood Test, immunoassay	\$22.22	N/A	None	None	Annually*
CPT code 82270	Fecal Occult Blood Test (e.g., guaiac)	\$4.54	N/A	None	None	Annually*

* Requires written order from the patient's attending physician. Medicare will pay for either the immunoassay-based Fecal Occult Blood Test (HCPCS code G0328) or the guaiac-based test, but will only pay for 1 test annually, not both.

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Ambulance Service Claims: National Provider Identifier (NPI) Reporting Requirements

What You Need to Know

CR 5564, from which this article is taken, notifies carriers and Medicare Administrative Contractors (MACs) to not require you to include the ordering/referring physician's National Provider Identifier (NPI) on your claims for ambulance services.

You should make sure that your billing staffs are aware of this exception.

Background

Section 1833(q) of the Social Security Act (the Act), requires that the ordering/referring physician's name be provided on all claims for Medicare covered services and items resulting from a physician's order or referral. In addition, when the NPI reporting requirements go into effect according to the Medicare fee-for-service NPI contingency plan, the ordering/referring physician's NPI will also be required on these claims; except, however, on claims for ambulance services (as explained in the paragraphs below). (See MLN Matters article, MM 5595, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> for details about the NPI contingency plan.)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. In response to this mandate, the Centers for Medicare and Medicaid Services (CMS) in the National Provider Identifier (NPI) final rule (published on January 23, 2004) established the NPI as this standard.

Although providers/suppliers may begin reporting the NPI as early as January 1, 2007, all health care providers covered under HIPAA must comply with the requirements of the NPI final rule in accordance with Medicare's NPI contingency plan. At the appropriate date, Medicare will reject claims in which the appropriate name and NPI are not entered in the required fields of the Form CMS-1500 paper claim format, version 08-05 (fields 17 and 17B, respectively), and the ANSI X12 837-P electronic claim format, version 4010A (NM1 segment of the 2310A and/or 2420E loop, respectively).

However, ambulance services (particularly transports provided in response to a 911 or 911-equivalent emergency call) are often ordered by someone other than a physician. In these situations, the name and the NPI of the ordering/referring physician are not available. Thus, CMS does not feel that it is appropriate to require that this information be submitted on the claim form. Therefore, CR 5564, from which this article is taken, instructs carriers and the Medicare Administrative Contractors (MACs) that the ordering/referring physician's NPI is not required on claims for ambulance services.

Additional Information

You can find the official instruction, CR 5564, by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1251CP.pdf>.

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

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Percutaneous Transluminal Angioplasty (PTA)

Impact to You

On August 2, 2006, a request to reconsider the national coverage determination (NCD) for PTA and stenting of the carotid arteries initiated a national coverage analysis. Change request (CR) 5660 communicates the findings resulting from that analysis.

What You Need to Know

Effective for dates of service performed on and after April 30, 2007, be aware of:

- Clarifications regarding the use of PTA and stenting of the carotid arteries for patients at high risk for carotid endarterectomy (CEA) and
- **Note the process that facilities must follow for certification and recertification** that is specified in section 20.7 of Publication 100-03, the *Medicare National Coverage Determinations Manual*.

What You Need to Do

If you are a provider of PTA and stenting of the carotid arteries services be aware that CMS has reviewed the evidence and determined that **coverage for this NCD is unchanged** and that **facilities should follow the certification/recertification guidelines in CR 5660**. See the *Background and Additional Information* sections of this Medicare Modernization Act (MMA) update.

Background

On April 22, 2005, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 3811 providing Medicare coverage for PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). This national coverage determination (NCD) is contained in section 20.7 of the *Medicare National Coverage Determinations Manual* and the **changes in the NCD are listed below**. To read the entire section of the NCD click on the *official instruction* issued with this change request that may be found in the *Additional Information* section of this article.

PTA is covered when used under the following conditions:

- Treatment of Atherosclerotic Obstructive Lesions.
- In the lower extremities, i.e. the iliac, femoral, and popliteal arteries.
- In the upper extremities, i.e. the innominate, subclavian, axillary, and brachial arteries, but not head or neck vessels.
- Of a single coronary artery.
- Concurrent with Carotid Stent Placement.
- Food and Drug Administration (FDA)-Approved Category B Investigational Device Exemption (IDE) Clinical Trials Effective July 1, 2001.

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- FDA-Approved Post Approval Studies--Effective October 12, 2004.
- Patients at High Risk for Carotid Endarterectomy (CEA)--Effective March 17, 2005.

NOTES: Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted given the risks of carotid artery stenting (CAS) without distal embolic protection.

- Concurrent with Intracranial Stent Placement
- FDA-Approved Category B IDE Clinical Trials--Effective November 6, 2006.

CAS for patients who are not at high risk for CEA remains covered only in FDA-approved Category B IDE clinical trials under 42 CFR 405.201.

CMS has determined that PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent is not reasonable and necessary for all other patients.

Facilities Certification

Facilities must be certified for Medicare to cover the CAS procedures and must recertify every two (2) years in order to maintain Medicare coverage of CAS procedures. Recertification will occur when the facility documents that and describes how it continues to meet the CMS standards. The new recertification guidelines are as follows:

At 23 months after initial certification:

- Submission of a letter to CMS stating how the facility continues to meet the minimum facility standards as listed in Section 20.7 of the *Medicare National Coverage Determinations Manual*. (See the *Additional Information* section of this article for the Web link to the NCD within CR 5660)

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At 27 months after initial certification:

- Submission of required data elements for all CAS procedures performed on patients during the previous two (2) years of certification.
- Required data elements:
 - Patients' Medicare identification number if a Medicare beneficiary;
 - Patients' date of birth;
 - Date of procedure;
 - Does the patient meet high surgical risk criteria (defined below)?
 - Age ≥ 80 ;
 - Recent (< 30 days) Myocardial Infarction (MI);
 - Left Ventricle Ejection Fraction (LVEF) < 30%;
 - Contralateral carotid occlusion;
 - New York Heart Association (NYHA) Class III or IV congestive heart failure;
 - Unstable angina: Canadian Cardiovascular Society (CCS) Class III/IV;
 - Renal failure: end stage renal disease on dialysis;
 - Common Carotid Artery (CCA) lesion(s) below clavicle;
 - Severe chronic lung disease;
 - Previous neck radiation;
 - High cervical Internal Carotid Artery (ICA) lesion(s);
 - Restenosis of prior carotid endarterectomy (CEA);
 - Tracheostomy;
 - Contralateral laryngeal nerve palsy.
 - Is the patient symptomatic (defined below)?
 - Carotid Transient Ischemic Attack (TIA) persisting less than 24 hours;
 - Non-disabling stroke: Modified Rankin Scale <3 with symptoms for 24 hours or more;
 - Transient monocular blindness: amaurosis fugax;
 - Modified Rankin Scale score if the patient experienced a stroke;
 - Percent stenosis of stented lesion(s) by angiography;
 - Was embolic protection used?
 - Were there any complications during hospitalization (defined below)?
 - Stroke: an ischemic neurologic deficit that persisted more than 24 hours
 - MI
 - Death

Recertification is effective for two (2) additional years during which facilities will be required to submit the requested data every April 1 and October 1.

CMS will consider the approval of national carotid artery stenting registries that provide CMS with a comprehensive overview of the registry and its capabilities, and the manner in which the registry meets CMS data collection and evaluation requirements. Specific standards for CMS approval are listed below.

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Facilities enrolled in a CMS approved national CAS registry will automatically meet the data collection standards required for initial and continued facility certification. Hospitals' contracts with an approved registry may include authority for the registry to submit required data to CMS for the hospital. A list of approved registries will be made available on the CMS coverage Web site. In addition, CMS will publish a list of approved facilities in the Federal Register.

National Registries

As noted above, CMS will approve national registries developed by professional societies and other organizations and allow these entities to collect and submit data to CMS on behalf of participating facilities to meet facility certification and recertification requirements. To be eligible to perform these functions and become a CMS approved registry, the national registry, at a minimum, must be able to:

1. Enroll facilities in every US state and territory;
2. Assure data confidentiality and compliance with HIPAA;
3. Collect the required CMS data elements as listed above;
4. Assure data quality and data completeness;
5. Address deficiencies in the facility data collection, quality, and submission;
6. Validate the data submitted by facilities, as needed;
7. Track long term outcomes such as stroke and death;
8. Conduct data analyses and produce facility specific data reports and summaries;
9. Submit data to CMS on behalf of the individual facilities; and
10. Provide quarterly reports to CMS on facilities that do not meet or no longer meet the CMS facility certification and recertification requirements pertaining to data collection and analysis.

Registries wishing to receive this designation from CMS must submit evidence that they meet or exceed these 10 requirements. Though the registry requirements pertain to CAS, CMS strongly encourages all national registries to establish a similar mechanism to collect comparable data on CEA. Having both CAS and CEA data will help answer questions about carotid revascularization, in general, in the Medicare population.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5660) issued to your Medicare carrier, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R71NCD.pdf>.

Change Request 3811 that is referenced in the *Background Section* of this article can be reviewed by clicking on the following link <http://www.cms.hhs.gov/MLNMArticles/downloads/MM3811.pdf>.

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

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CPT Modifiers 54 & 55

Date of Service and CPT Codes Must Match

When physicians agree on the transfer of care during the global surgery period, the following modifiers must be used:

- CPT Modifier 54 - for surgical care only
- CPT Modifier 55 - for postoperative management only

The claim for the surgical care AND the claim(s) for the postoperative care must contain the **SAME** date of service and the **SAME** surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Appropriate:

Date	CPT code/modifier	Surgeon/Physician
5/8/07	66982-54	Surgeon
5/8/07	66982-55	Post-op Care Physician

Inappropriate:

Date	CPT code/modifier	Surgeon/Physician
5/8/07	66982-54	Surgeon
5/9/07	66984-55	Post-op Care Physician

The surgeon and the physician(s) providing the post-operative care must collaborate to ensure the appropriate date of service and surgical code are submitted (with the appropriate CPT modifier).

Claims are being monitored and will be rejected when submitted inappropriately.

For more information regarding global surgery and transfer of care during the global surgery period, refer to Sections 40.2 - 40.4 at the following CMS Web site address: <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Medical Review – Frequently Asked Questions Answered for You!

Does Medicare cover hand therapy or pet therapy?

Answer: No. Charges for hand therapy and pet therapy are not covered by Medicare. These services may not be submitted to Medicare using codes for psychotherapy because they do not meet the definition of psychotherapy and are not considered a Medicare benefit. If the patient insists that the charges be submitted, you may submit them for denial purposes using CPT code 90899 and HCPCS modifier GY.

How should we calculate the time for time-based psychotherapy services, for the purposes of submitting claims?

Answer: In order to submit a code for time-based psychotherapy, the time that the therapist spends face-to-face with the beneficiary doing psychotherapy must be at least the minimum number of minutes specified by the CPT code. If the face-to-face time spent was less than the minimum, submit the lower code.

Is it appropriate to submit a Health & Behavior code for a patient that has dementia?

Answer: Palmetto GBA does not have specific diagnosis restrictions in place for health and behavior codes (CPT codes 96150-96155). If the patient with dementia can benefit from these procedures (i.e., if they have a condition for which it is appropriate to perform these services and the services meet the definition of “medically necessary”), you may submit them to Palmetto GBA for consideration.

Can a psychologist order neuropsychological tests?

Answer: No. Psychologists do not meet the definition of a “physician” for the purposes of ordering tests for Medicare patients. Reference: CMS Pub. 100-01, Chapter 1, Section 70: <http://www.cms.hhs.gov/manuals/downloads/ge101c05.pdf>.

Can a psychologist order basic lab tests?

Answer: No. Psychologists do not meet the definition of a “physician” for the purposes of ordering tests for Medicare patients. Reference: CMS Pub. 100-01, Chapter 1, Section 70: <http://www.cms.hhs.gov/manuals/downloads/ge101c05.pdf>.

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Trichiasis: Coding Guidelines

This article provides information about how to submit claims for correction of trichiasis (removal of inwardly growing eyelash(es)).

CPT codes 67820 and 67825:

Correction of Trichiasis, by epilation

CPT codes 67830 and 67835:

Correction of Trichiasis, incision of lid margin

Coding Guidelines:

- When the above codes are submitted on a claim, report the codes **PER PROCEDURE**; not per eyelash or per eyelid.
- When performed **unilaterally**, the quantity-billed field (days/units) must be “one.”
- When performed **bilaterally** on the same date of service, submit on the same detail line with CPT modifier 50. The quantity-billed field (days/units) must be “one.” If it is necessary to submit the bilateral service on separate lines or claims, submit the correct CPT code with HCPCS modifier RT on one line, the CPT code with HCPCS modifier LT on a separate line. Submit the quantity-billed field as “one” on each detail.
- Incorrectly coded services will be rejected as unprocessable (remark code MA130). These claims must be corrected and resubmitted as new claims. You may not submit Redetermination Requests for these billing errors.

Unilateral Trichiasis: Coding Example

Date	CPT code	HCPCS modifier	Quantity
01/01/2007	67820	RT	1

Bilateral Trichiasis: Coding Example

Date	CPT code	CPT modifier	Quantity
02/28/2007	67820	50	1

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Vagus Nerve Stimulation (VNS) for Resistant Depression

Provider Action Needed

CR 5612, from which this article is taken, announces that CMS is issuing a national (non) coverage determination (NCD) stating that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression.

Therefore, effective May 4, 2007, CMS will deny VNS claims when resistant depression is the indication for the procedure.

Background

Vagus Nerve Stimulation (VNS) utilizes a battery-powered pulse generator (similar to a pacemaker), that is surgically implanted under the skin of the left chest and an electrical lead (wire) connected from the generator to the left vagus nerve; through which electrical signals are sent to the brain.

In 1999, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) that (effective for services performed on or after July 1, 1999) VNS is reasonable and necessary for patients with medically refractory partial onset seizures when surgery is not recommended or has failed.

On August 7, 2006, a formal request to reconsider resistant depression as an additional indication initiated a national coverage analysis, and CR 5612, from which this article is taken, communicates the findings of that analysis. Specifically in CR 5612, CMS announces that it has reviewed the evidence and has concluded that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression under §1862(a)(1)(A) of the Social Security Act, and has issued a national noncoverage determination for this indication.

Therefore, effective May 4, 2007, CMS will deny or reject, as appropriate, VNS claims for resistant depression, as specified in the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2 (Sections 90 – 160.25 (Coverage Determinations)), Section 160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications)).

CR 5612 contains some specifics about VNS coverage that you should be aware of:

- Carriers, FIs, and A/B MACs will continue to pay VNS claims for medically refractory partial onset seizures as specified in section 160.18.B of the *Medicare National Coverage Determination Manual*, identified when any of the following ICD-9-CM diagnosis codes appear on the claim:
 - 345.41 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy),
 - 345.51 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures with intractable epilepsy), or

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- Carriers, FIs, and A/B MACs will continue to deny/reject VNS claims for all other types of seizures as specified in section 160.18.C of the *Medicare National Coverage Determination Manual*.
- Physicians and hospitals will be liable for noncovered VNS procedures unless they issue an appropriate advance beneficiary notice (ABN), which should include the following language:
 - **Items or Service Section:** “Vagus Nerve Stimulation”.
 - **Because Section:** “As specified in section 160.18 of Pub.100-03, Medicare National Coverage Determination Manual, Medicare will not pay for this procedure as it is not a reasonable and necessary treatment for (select either “your type of seizure disorder” or “resistant depression.”)”
- When denying non-covered VNS services carriers, FIs, and A/B MACs will use the following messages:
 - Medicare Summary Notice (MSN) 16.10 “Medicare does not pay for this item or service;”
- Claim Adjustment Reason Code (CARC) 50: “These are non-covered services because this is not deemed a “medical necessity” by the payer;” and
- One of the following Remittance Advice Remark Code (RARC) messages, depending on liability:
 - M27 Alert: “The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient’s waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office;”
or

- M38 “The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.”
- Medicare carriers, FIs, and A/B MACs will also include group code CO (contractual obligation) or PR (patient responsibility) depending on liability.
- Carrier, FIs, and A/B MACs will not search their files to retract payment for claims already paid, but will adjust claims brought to their attention.

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Finally, you should remember that this addition/revision of section 160.18 of the *Medicare National Coverage Determination Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). A NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Additional Information

You can find the official instruction issued to your carrier, FI, or A/B MAC about the VNS NCD by looking at the two transmittals for CR 5612. The first transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R70NCD.pdf>. That transmittal contains the amended *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2 (Sections 90 – 160.25 -- Coverage Determinations), Section 160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications)). The second transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1271CP.pdf> and it contains the amended *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 200 (Billing Requirements for Vagus Nerve Stimulation (VNS)).

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

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
Radiation Oncology Services 2000-03LR19.1	Revised Policy Addition of CPT code 0073T to policy. Added under Indications and Limitations section the definition of High-dose rate (HDR) brachytherapy. Addition of ICD-9 codes 336.9 and 459.2 to support medical necessity for IMRT.	8/15/07
Paravertebral Facet Joint Block 2000-31LR7.1	Revised Policy Clarification of frequency limitation under Utilization Guidelines for therapeutic blocks.	8/1/07
Skin Substitutes for Wound Healing 2005-07LR2.1	Revised Policy Language added to Indications and Limitations section indicating non-coverage for any wound treatment that does not meet the definition of either HCPCS code J7340 or J7342. Addition of HCPCS code J7341 with ICD-9 codes as supporting medical necessity 250.80 – 250.83, 454.0, 454.2, 459.31, 459.33, 707.00-707.09, 707.12-707.15, 941.20-941.21, 941.24-941.29, 942.20-942.29, 943.20-943.29, 944.20-944.28, 945.20-945.29, 946.2 and 949.2.	8/1/07
Non-covered Category III CPT codes 2007-01L1.1	New Policy The AMA developed CPT Category III Codes to track the utilization of new and emerging technologies, services and procedures. Not all Category III Codes have been established as safe and effective in order to be considered medically necessary. As a result, this policy was written to automate exclusion of coverage of all Category III CPT Codes that have not been specifically listed as covered in other NCDs, LCDs and articles.	8/1/07

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LCD	Change	Effective Date
Chemotherapy & Biologicals 2002-29LR30.3	New Policy Policy was created and consolidated with SC to provide consistency across all jurisdictions and to include chemotherapeutic agents and biologicals.	8/1/07
Cancer Chemotherapy & Chemotherapeutic Agents 2002-29LR29.3	Retired Replaced with Chemotherapy & Biologicals LCD.	8/1/07
Allergen Immunotherapy 2000-28LR8	Addition of ICD-9 code 995.3 as supporting medical necessity for CPT codes 95115 and 95117.	8/1/07
Bone Mass Measurement 2001-37LR17	Per Change Request 5521, removed ICD-9 codes 255.0, 733.00-733.09 and 733.90 as supporting medical necessity for CPT codes 76977, 77078, 77079, 77081, 77083 and HCPCS code G0130. Verbiage changes to Indications and Limitations section.	1/1/07

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Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 1279, 06-29-07)

30.3.13 - Charges for Missed Appointments

30.3.13 – Charges for Missed Appointments

(Rev. 1279; Issued: 06-29-07; Effective: 10-01-07; Implementation: 10-01-07)

CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The amount that the physician or supplier charges for the missed appointment must apply equally to all patients (Medicare and non-Medicare), in other words, the amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients (whatever amount that may be).

With respect to Part A providers, in most instances a hospital outpatient department can charge a beneficiary a missed appointment charge without violating its provider agreement and 42 CFR 489.22. Because 42 CFR 489.22 applies only to inpatient services, it does not restrict a hospital outpatient department from imposing charges for missed appointments by outpatients. In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers. Charges to beneficiaries for missed appointments should not be billed to Medicare.

If contractors receive any claims for missed appointment charges, the following reason code and MSN messages should be used to deny the claims—

Reason Code 204: This service/equipment/drug is not covered under the patient's current benefit plan.

MSN messages:

16.59 - Medicare doesn't pay for missed appointments.

16.59 – Medicare no paga por citas médicas a las que no se presentó.

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, if you wish. If you do not indicate an effective date, the date we receive and approve this form will become your effective date.

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/boh/forms> (Ohio) or <http://www.PalmettoGBA.com/bwv/forms> (West Virginia).

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: _____
Claim Number (ICN): _____
Date of initial determination: _____
*Date of Service: _____
*CPT code(s): _____
ICD-9 code(s): _____
Billed Charge: _____

*** Indicates required fields.**

Provider Name: _____
Billing provider number: _____
Provider Phone Number: _____
Who are you:
 Provider
 Provider's Representative
 Patient with Medicare
 Patient's Representative
 Other

This is an appeal for:

- | | | |
|---|--|--|
| <input type="checkbox"/> Ambulance service | <input type="checkbox"/> Duplicate service | <input type="checkbox"/> Psychiatric service |
| <input type="checkbox"/> Chiropractic service | <input type="checkbox"/> Limitation of Liability (LOL) service | <input type="checkbox"/> Radiology service |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Podiatry service | <input type="checkbox"/> Other |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Remittance Notice (please attach) | <input type="checkbox"/> Medical Necessity Statement | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Advance Notice Statement | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Claim Copy | <input type="checkbox"/> Operative/Pathology Report | <input type="checkbox"/> Ambulance Run Report |

Reason for request: _____

* Requestor (signature required); _____ Current Date: _____

Name: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Phone Number: _____

**Palmetto GBA,
Medicare Appeals, QA-555
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 completed/include information for items 1, 2a, 6, & 7**, but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

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

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

Contractor Number: 00883

Palmetto GBA –Ohio Medicare Part B Carrier
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (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 completed/include information for items 1, 2a, 6, & 7**, but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

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

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

Contractor Number: 00884

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