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Medicare advisory

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2006, Issue 12 *www.cms.hhs.gov* *www.PalmettoGBA.com* *December 2006*

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You Are Responsible. . .

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

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

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Palmetto Place

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

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

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

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

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Beneficiary Eligibility: The Wave of the Future

Verifying patients' eligibility for Medicare is a necessary but time-consuming process for medical practices. Currently, many providers verify eligibility through the Interactive Voice Response unit (IVR).

CMS offers real-time Internet-based eligibility transactions as an alternative to the IVR. These ANSI "270/271" transactions are processed through the CMS data center. Providers and clearinghouses must be authenticated by CMS before conducting these transactions. Telecommunications software is also required in order to access the CMS network.

Steps to obtain access for Internet eligibility (270/271) transactions:

- In order to obtain access to the CMS 270/271 Medicare Eligibility transaction from the Medicare Data Communication Network (MDCN), you must access the appropriate forms at http://www.cms.hhs.gov/AccessToDataApplication (new Web site address).
  - Complete the **Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis**. This agreement outlines security and privacy procedures for the Medicare beneficiary database. Complete all the information on the form electronically and click on the appropriate assurances. If you do not consent to the terms of the agreement, the access process will be terminated.
  - If you check the appropriate boxes of the agreement and supply the information requested, a copy of the completed form will be electronically submitted to the CMS 270/271 Medicare Eligibility Integration Contractor (MEIC) for security authentication.
  - The access process will then continue, and you will be directed to complete an **MDCN Connectivity Form**. This form must be submitted electronically in order for you to be connected to the 270/271 eligibility database.
  - CMS will ensure that all necessary information is provided on the forms, and ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the clearinghouses, providers, and trading partners to authenticate the accessing entity's identity. Once authentication has been completed, the MEIC will provide you with a submitter ID that must be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent in real-time.
  - Please note that in order to access the MDCN, you must obtain the necessary telecommunications software from the AT&T reseller on your own. The current AT&T resellers and contact numbers are listed below:
    - IVANS: http://www.ivans.com; 1-800-548-2675
    - McKesson: http://www.mckesson.com;1-800-782-7426, option 5, then key option 8

Additional resources:

- The EDI Technical Support Help Desk: 1-866-308-5438
- In Ohio, e-mail us directly from the Ohio Web site. Go to http://www.PalmettoGBA.com/boh, then select Contact Us.
- In West Virginia, e-mail us directly from the West Virginia Web site. Go to http://www.PalmettoGBA.com/bwv, then select Contact Us.

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Medicare Deductible, Coinsurance & Premium Rates for 2007

Provider Action Needed

This article is based on Change Request (CR) 5345 which announces the 2007 Medicare rates and instructs your Medicare contractors to make necessary updates to their claims processing systems.

Background

There are beneficiary-related costs for using certain services under Parts A and B of Medicare, typically in the form of deductibles, co-payments, and/or premium payments. Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for **more than 60 days** during a spell of illness, he or she is responsible for **a coinsurance amount equal to one-fourth** of the inpatient hospital deductible for the 61st and 90th day spent in the hospital.

An individual has 60 lifetime reserve days (LRDs) of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these LRDs is equal to one-half of the inpatient hospital deductible.

For Skilled Nursing Facility (SNF) services furnished during a spell of illness, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st and through the 100th day.

Most individuals **age 65 and older**, and many **disabled individuals under age 65**, are **insured for Health Insurance (HI) benefits without a premium payment**. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium.

Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment occurs more than 12 months after the date a person is initial eligibility to enroll, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under **Supplementary Medical Insurance (SMI) or Part B**, all enrollees are **subject to a monthly premium**. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When SMI enrollment takes place more than **12 months after a person's initial enrollment** period, there is a permanent **10 percent increase in the premium** for each year the beneficiary could have enrolled and failed to enroll.

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Medicare Part A for 2007

For Calendar Year (CY) 2007, the following rates are applicable for Medicare Part A Deductible, Coinsurance, and Premium amounts:

Deductible	$992.00 per benefit period
Coinsurance	$248.00 a day for days 61-90 in each period
	$496.00 a day for days 91-150 for each LRD used
	$124.00 a day in a SNF for days 21-100 in each benefit period
Premium	$410.00 per month for those who must pay a premium
	$451.00 per month for those who must pay both a premium and a 10 % increase
	$226.00 per month for those who have 30-39 quarters of coverage
	$248.60 per month for those who have 30-39 quarters of coverage and must pay a 10 % increase

Medicare Part B for 2007

For CY 2007, the following rates are applicable for Medicare Part B Deductible and Coinsurance:

Deductible	$131.00 per year
Coinsurance	20 percent

CMS updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium	Year	Part B Premium	Year	Part B Premium
2006	$88.50	2002	$54.00	1998	$43.80
2005	$78.20	2001	$50.00	1997	$43.80
2004	$66.60	2000	$45.50	1996	$42.50
2003	$58.70	1999	$45.50		

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Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary. Below are the CY 2007 **Part B premium amounts based on beneficiary income parameters**.

Income Parameters for Determining Part B Premium		
Premium/month	**Individual Income**	**Combined Income (Married)**
$ 93.50	$ 80,000.00 or less	$160,000.00 or less
$105.80	$ 80,000.01 - $100,000.00	$160,000.01 - $200,000.00
$124.40	$100,000.01 - $150,000.00	$200,000.01 - $300,000.00
$142.90	$150,000.01 - $200,000.00	$300,000.01 - $400,000.00
$161.40	$200,000.01 or more	$400,000.01 or more

Implementation

The implementation date for CR 5345 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC,DME MAC, intermediary, RHHI, or A/B MAC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R41GI.pdf on CMS' Web site.

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

Care Plan Oversight Services (CPO): Alert

A *MLN article* published in the August *Medicare Advisory* for Non-Physician Practitioner (NPP) Payment for Care Plan Oversight (CPO), which stated that "currently there is no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number required for a CPO claim. For this reason, the requirement to include the HHA or hospice provider number on a CPO claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for CPO claims."

Providers should be aware that for claims with dates of service January 1, 2005, and after, claims submitted with the home health or hospice provider number will be returned as unprocessable.

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Returning Paper Claims Received From Clearinghouses

Provider Impact

If a clearinghouse submits claims for you on paper (rather than electronically), your payments may be affected. The Administrative Simplification Compliance Act (ASCA) requires that claims a clearinghouse submits to Medicare on your behalf must be submitted electronically. When your carrier or fiscal intermediary (FI) identifies that a clearinghouse has submitted a claim for you on paper, they will return the claim unprocessed to the clearinghouse.

Background

Section 3 of the Administrative Simplification Compliance Act (ASCA), PL 107-105; the implementing regulation at 42 CFR 424; and the ***Medicare Claims Processing Manual*** Chapter 24, Section 90-90.6 and its exhibits all require (except in limited situations) that you submit claims to Medicare electronically. And, while ASCA regulations do allow you (as a provider) to submit some, or all, claims on paper in very specific and limited instances; HIPAA covered entities (other than providers) are not eligible for an exemption from these electronic Medicare claim submission requirements.

CR 5341, from which this article is taken, addresses claims that your clearinghouse submits to Medicare on your behalf. To be specific, if you contract with a clearinghouse to send claims to Medicare for you, they are required to submit these claims electronically.

There is evidence that some clearinghouses are routinely submitting paper claims without the providers' knowledge. You should be aware that your carriers and FIs, having identified that a provider's clearinghouse has submitted your claims in paper form, will return them to the clearinghouse without action.

Additional Information

The official instruction (CR 5341) issued regarding paper claims that they receive from clearinghouses is located on CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R247OTN.pdf.

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

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Revised Health Insurance Claim Form CMS-1500: Additional Requirements

Note: Page 3 of this article was revised on October 13, 2006, to reflect that the **appropriate NPI** must be entered in certain fields on Form CMS-1500. Previously, the article incorrectly stated the NPI of the billing provider. All other information remains the same.

Key Points

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

January 2, 2007 – March 30, 2007	Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. Note: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.
April 2, 2007	The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. Note: All rebilling of claims should use the revised Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

Background

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

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In a related Change Request, CR 4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

Billing Guidelines

When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be **rejected** (in most cases with reason code 16 – "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information, **if**

- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:
  - **24J** (replacing item 24K, Form CMS-1500 (12-90));
  - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
  - **33a** (replacing item 33, Form CMS-1500 (12-90)).

Additional Information

When the NPI Number is Effective and Required (May 23, 2007)

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

Additional NPI-Related Information

Additional NPI-related information can be found on CMS' Web site at http://www.cms.hhs.gov/NationalProvIdentStand/.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at http://www.nucc.org/images/stories/PDF/change_log.pdf .

MLN Matters article MM 4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be

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found on CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf. CR 4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found on CMS' Web site at http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf.

MLN Matters article MM 4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," can be found on CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf.

CR 5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM 5060. CR 5060 may be found by going to CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf.

If you have questions about this issue please contact our office at 1-877-567-9232.

Annual HCPCS/CPT Coding Update

Effective January 1, 2007, providers must use the HCPCS/CPT codes that are valid at the time the service is rendered. If claims are submitted with discontinued codes, the service will be rejected.

To ensure prompt and timely payment of claims, use the new HCPCS/CPT codes for 2007 beginning with services rendered on or after January 1, 2007. Each year thereafter, be sure to adopt the new codes.

CMS no longer allows a 90-day grace period for discontinued codes. This also applies to any mid-year HCPCS/CPT deletions.

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Medicare Education for Small Providers

Palmetto GBA OH/WV offers ongoing training opportunities tailored to small providers. These sessions are specifically designed for providers with fewer **than 10 full time employees.** All sessions include Medicare updates and reimbursement changes and are followed by a question and answer session. All specialties are welcome! Mark your calendars now so that you don't miss a chance to learn valuable information about how Medicare guidelines affect your practice.

Benefits of Attending

- ***Stay close to "home."*** Learn about Medicare guidelines and important changes in a location close to your office.
- ***Learn from others*** by attending a Small Provider Forum. Participants learn from each other's discussions and receive useful clarification regarding different Medicare policies and initiatives. We answer provider/supplier questions associated with coverage, coding, and reimbursement.
- ***See how things work*****,** first-hand, by watching demonstrations of how technology can work for you in the Medicare world.
- ***Receive personalized assistance***. Palmetto GBA Community Education Administrators will tailor training to meet your needs.

You Are Invited!

Palmetto GBA **Small Provider Forums offer training in a group setting**. Forums are available on the following dates:

Date	Time	City/State
November 29, 2006	1:00 – 4:00 PM	Weirton, WV
January 24, 2007	1:00 – 4:00 PM	Toledo, OH
February 7, 2007	1:00 – 4:00 PM	Columbus, OH
February 28, 2007	1:00 – 4:00 PM	Ripley, WV
March 14, 2007	1:00 – 4:00 PM	Medina, OH
April 18, 2007	1:00 – 4:00 PM	Springfield, OH
May 16, 2007	1:00 – 4:00 PM	Sandusky, OH
May 30, 2007	1:00 – 4:00 PM	Lewisburg, WV
June 20, 2007	9:00 AM – 12:00 PM	Hillsboro, OH
July 18, 2007	1:00 – 4:00 PM	Lorain, OH
August 1, 2007	1:00 – 4:00 PM	Zanesville, OH
August 29, 2007	1:00 – 4:00 PM	Martinsburg, WV

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How to Register

Registration for Small Provider Forums is easy. To register through the Internet, follow these steps:

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

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

No Internet access?

If you do not have Internet access, you may register for this event by faxing the Registration Form for Palmetto Small Provider Forums to 614-473-6812.

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

IMPORTANT: Seating is limited for all sessions. Reservations are required and will be accepted on a first-come, first-served basis.

- If you subscribe to our *free* e-mail update service, we will notify you in advance of the meeting locations and any additions to this schedule.
- We look forward to working with you!

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Registration Form for Palmetto GBA Small Provider Forums

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

Name: _____

Practice Name: _____

Practice Address: _____

_____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

_____ November 29, 2006, Weirton, WV
_____ January 24, 2007, Toledo, OH
_____ February 7, 2007, Columbus, OH
_____ February 28, 2007, Ripley, WV
_____ March 14, 2007, Medina, OH
_____ April 18, 2007, Springfield, OH
_____ May 16, 2007, Sandusky, OH
_____ May 30, 2007, Lewisburg, WV
_____ June 20, 2007, Hillsboro, OH
_____ July 18, 2007, Lorain, OH
_____ August 1, 2007, Zanesville, OH
_____ August 29, 2007, Martinsburg, WV

Name and number of persons attending: _____

To Be Completed by Palmetto GBA

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

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

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Free Therapy Services Medicare Part B Seminars

Palmetto GBA is presenting **FREE Therapy Services Seminars** in Ohio designed for Physical Therapists, Occupational Therapists, and Speech Language Pathologists. Representatives from Palmetto GBA will provide the latest Medicare documentation guidelines for Therapy Services and the Therapy CAP Exception Process.

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

Ohio Seminars

Date	Location	Time
Tuesday, November 28, 2006	Spring Hollow Lodge 1069 W. Main St. Westerville, OH 43081 Cannot be accessed from Sharon Woods entrance. Continue north on Cleveland Avenue, past the main park entrance to Main Street and turn left. Go about 1.5 miles and turn left into the park. Follow the park signs.	1:00 p.m. - 3:00 p.m.

Registration:

To Register for a seminar please go to:

- http://www.PalmettoGBA.com/boh/education for Ohio
- 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. For additional questions please call 1-877-567-9232, then select the option for education.

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Free Chiropractic Services Medicare Part B Seminar

Palmetto GBA is presenting a FREE Chiropractic Services Seminar in Ohio designed for Chiropractors. Representatives from Palmetto GBA will provide the latest Medicare documentation guidelines for Chiropractic Services.

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

Ohio Seminars

Date	Location	Time
Tuesday, November 28, 2006	Spring Hollow Lodge 1069 W. Main St. Westerville, OH 43081 Cannot be accessed from Sharon Woods entrance. Continue north on Cleveland Avenue, past the main park entrance to Main Street and turn left. Go about 1.5 miles and turn left into the park. Follow the park signs.	9:30 a.m. - 11:30 a.m.
Thursday, January 18, 2007	Spring Hollow Lodge 1069 W Main St. Westerville, OH 43081 Cannot be accessed from Sharon Woods entrance. Continue north on Cleveland Avenur, past the main park entrance to Main Street and turn left. Go about 1.5 miles and turn left into the park. Follow the park signs.	9:30 a.m. - 11:30 a.m.

Registration:

To Register for a seminar please go to:

- http://www.PalmettoGBA.com/boh/education for Ohio or http://www.PalmettoGBA.com/bwv/education for 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. For additional questions please call 1-877-567-9232 and select the option for education.

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Medicare Participating Physicians Directory (MEDPARD)

The Medicare Participating Physicians Directory (MEDPARD) containing the list of names, addresses, phone numbers, and specialties of all participating providers within the Medicare Part B Program may be accessed through the following state Web sites:

Ohio:

http://www2.palmettogba.com/medpard/ECom_MedPard_OH.jsp

West Virginia:

http://www2.palmettogba.com/medpard/ECom_MedPard_WV.jsp

South Carolina:

http://www2.palmettogba.com/medpard/ECom_MedPard_SC.jsp

You may also visit the CMS MEDPARD listing (physicians only) Web site at http://www.cms.hhs.gov/center/physician.asp . If you have questions regarding the MEDPARD directory information, please call Brenda Knox at 614-473-7169. MEDPARD paper requests by locality may be submitted to:

Medicare Disclosure
Palmetto GBA
Medicare Part B Operations
P.O. Box 182934
Columbus, OH 43218-2934

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Long-Term Care (LTC) Campaign: Own Your Future

Provider Types Affected

Physicians, providers, and their staff who provide health care to individuals between the ages of 45 - 65.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you about the Long-Term Care Awareness Campaign 'Own Your Future' - the first effort of its kind designed to increase public awareness about the need to plan for future long-term care needs. Providers in Georgia, Massachusetts, Michigan, Nebraska, South Dakota, and Texas, may want to take special note as consumers in those States will receive letters over the next year alerting them of the campaign to promote LTC planning and of the availability of a free Long-Term Care Planning Kit. You may want to reinforce the importance of such planning as you counsel your patients.

Background

Components of the U.S. Department of Health and Human Services (HHS), including the Office of the Assistant Secretary for Planning & Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS),and the Administration on Aging (AoA), are working with the National Governors Association to sponsor the Long-Term Care (LTC) Awareness Campaign, "Own Your Future." The LTC Awareness Campaign represents a unique partnership between the federal government and the states to offer an important message to consumers about planning ahead for long-term care.

The LTC Awareness Campaign is an effort to increase public awareness of the need to plan for future long-term care needs. Many people today do not think about their future long-term care needs and therefore fail to plan appropriately. It is strongly felt that if individuals and families are more aware of their potential need for long-term care, they will be more likely to take steps to prepare for the future and determine how they would like their needs to be met.

The LTC Awareness Campaign includes evaluation activities designed to identify communication strategies that prove most effective in increasing awareness and promoting increased long-term care planning activities. The lessons learned from this campaign will be used in the design of future long-term care awareness campaigns in other states.

The Campaign is now entering a third phase and builds upon the successes achieved in the first two phases in which nine states participated (Arkansas, Idaho, Kansas, Maryland, Nevada, New Jersey, Rhode Island, Virginia and Washington). It is supported with additional funds made available by Congress under the Deficit Reduction Act of 2005.

Additional Information

The LTC Awareness Campaign uses long-term care awareness materials that were designed, tested, and approved as part of an earlier awareness effort, and the materials include the following:

- Brochure (with business reply card) offering the Long-Term Care Planning Kit.

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- Long-Term Care Planning Kit featuring:
  - A brochure describing what is, and what is not, covered by public programs related to long-term care. The brochure also describes several ways to plan ahead, addressing legal issues, assessing services, and assessing private financing options.

    An audio CD with interviews of persons engaged in several different types of long-term care planning activities. Consumers in campaign states may order the free Planning Kit by telephone (1-866-PLAN LTC), business reply card, or at a newly-created consumer Web site (http://www.aoa.gov/ownyourfuture). Individuals outside the LTC Awareness Campaign states can download the Planning Kit at the consumer Web site (http://www.aoa.gov/ownyourfuture), or they can order and receive the free "Own Your Future" Planning Kit by calling 1-866-PLAN-LTC.

Additional important materials associated with the "Own Your Future" campaign are available at http://www.cms.hhs.gov/center/longtermcare.asp on the CMS Web site. The materials present issues and decisions that anyone thinking about long-term care may encounter such as:

- Home modification(s),
- Family care-giving dynamics, and
- Financing of care.

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CMS Quarterly Provider Update

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

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

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

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

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Telephone Reopening Line

Providers and Beneficiaries may request a Reopening of their Medicare claim over the telephone. Requests to reopen an initial claim to correct minor errors or omissions can be made by contacting our toll free line at **1-866-308-5441** between **9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 3:00 p.m. (EST)**, Monday through Friday. A maximum of three (3) requests can be handled during the same telephone call.

Requests for claim status or questions about why a claim denied are considered inquiries, not reopenings. Calls about an inquiry will be referred back to the Customer Service Center for assistance.

NOTE: If your claim has been rejected as unprocessable (MA130), a corrected, new claim must be submitted. Corrections will not be made on this line.

When calling our office to **request a claim correction**, please be prepared to provide the following information:

- *The provider's/physician's/supplier's name and identification number or National Supplier Clearinghouse number;*
- *Beneficiary last name, first initial; and*
- Medicare HICN.

NOTE: **The above items must match exactly**. If not, you may be instructed to research this information and call back or write in for your request.

Claim corrections can include:

- *Mathematical or computational mistakes;*
- *Transposed procedure or diagnostic codes;*
- *Inaccurate data entry;*
- *Misapplication of a fee schedule;*
- *Computer errors; or,*
- *Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate.*
- Incorrect data items, such as provider number, use of a modifier or date of service (month and day only).

The addition/correction of the listed modifiers may be handled as reopenings on this line.

HCPCS Modifiers	AA, AD, AT, E1, E2, E3, E4, GA, G8, G9, GV, GW, LT, KD, KX, QJ, QK, QR, QW, QX, QY, QZ, Q3, RT, SG, TC
CPT Modifiers	21, 25, 26, 50, 51, 54, 57, 58, 59, 66, 73, 74, 76, 77, 78, 79, 80, 82

All other modifiers may be submitted, with supporting documentation, as written requests for a Reopening or a Redetermination.

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The following **are not appropriate** for telephone reopenings, but do have exceptions:

- **Ambulance claims**: The only exception is for a duplicate denial for same trip (same origin and destination modifiers), on the same day. A reopening may be done if specific information is provided to support two separate trips. A reopening may not be done via the telephone if medical necessity is the issue.

- **MSP (Medicare Secondary Payer) claims**: The only exception is if the Beneficiary's records are updated to show Medicare as primary and the carrier denied and or paid the claim as secondary.

The following issues are redeterminations and must be submitted in writing:

- *Limitation on liability;*
- *Medical necessity denials and reductions; or*
- *Analysis of documents such as operative reports and clinical summaries.*
- *Claims requiring the input of medical staff or other entities outside of the reopenings department and "big box" cases.*

A reopening to add items or services that were not previously billed will not be completed. A written request must be filed.

Please see the 'Cheat Sheet' for reopenings, which is a handy reference to use when calling to request a reopening of a claim.

****The contractor has discretion in determining what meets the definition of a reopening and therefore, what could be corrected through a reopening.

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Telephone Reopening Reference Guide

The contractor has discretion in determining what meets the definition of a reopening and therefore, what could be corrected through a reopening

Number to call	1-866-308-5441
When to call	9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 3:00 p.m. (Eastern Standard Time) Monday through Friday
What information to have ready when calling	**Provider Number** **Patient's Last Name and First Initial** **Medicare Number** ***IMPORTANT: These items MUST match exactly. If not, the reopening request will not be accepted.***
Definition of reopening	• Mathematical or computational mistakes; • Transposed procedure or diagnostic codes; • Inaccurate data entry; • Misapplication of a fee schedule; • Computer errors; or, • Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate, For example: ambulance trip denied as duplicate, but were trips at 2 different times of the day • Incorrect data items, such as provider number, use of a modifier or date of service (month and day only). Note: For claims rejected as unprocessable (MA130 on the remittance notice); a corrected, new claim must be submitted
Qualifying modifier corrections	**HCPCS modifiers: AA, AD, AT, E1, E2, E3, E4, GA, G8, G9, GV, GW, LT, KD, KX, QJ, QK, QR, QW, QX, QY, QZ, Q3, RT, SG, TC** **CPT modifiers: 21, 25, 26, 50, 51, 54, 57, 58, 59, 66, 73, 74, 76, 77, 78, 79, 80, 82** ***Note: Others may require documentation and should be requested in writing.***

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Issues not telephone reopenings should be requested in writing	• Limitation on liability; • Medical necessity denials and reductions; or • Analysis of documents such as operative reports and clinical summaries. • **Claims requiring the input of medical staff or other entities outside of the reopenings department and "big box" cases;** • **Requests to add items or services not originally billed**
Points to remember	Three (3) qualifying requests for reopening will be taken per telephone call

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Reopenings & Revisions of Claim Determinations & Decisions

Impact to You

This article, based on Change Request (CR) 4147, notifies you about changes to the *Medicare Claims Processing Manual*, which ensure that claims with **clerical errors (which include minor errors and omissions)** should be processed as "**reopenings**" and not as "**appeals.**"

What You Need to Know

All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added "Missing data items, such as provider number or missing date of service" to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors.

What You Need to Do

Please refer to the *Additional Information* section of this article and to the information in the manual attachment to CR 4147 (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of *The Medicare Claims Processing Manual*.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

Additional Information

"A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record." (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10.) If your reopening request is denied, you may not appeal the contractor's refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. **Requesting a reopening does not toll the timeframe to request an appeal.** If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP

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beneficiary or provider /supplier recovery claims are initial determinations.

- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department if the following conditions are met:
  1. A provider failed to timely submit documentation requested through an ADR
  2. The claim was denied because the requested documentation was not received tinely
  3. The requested documentation is received after the 45-day period with or without a request for redetermination or reopening; and
  4. The request is filed within 120 days of the date of receipt of the initial detemination.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/ physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. **NOTE: Items must match exactly.**

CR 4147 is the official instruction regarding changes mentioned in this article. CR 4147 may be found by going to CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf.

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 or Chapter 34, Section 10 of the *Medicare Claims Processing Manual*, which is available at http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf.

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

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Qualified Independent Contractor (QIC)

First Coast Service Options, Inc. Begins QIC Part B North operations effective November 15, 2006

As you are aware, a separate contractor called a Qualified Independent Contractor, or "QIC", handles second level appeals, termed "reconsiderations". Beginning November 6th, 2006, all redetermination letters, which communicate the results of the first level of appeal, will include instructions on how to request a reconsideration to the new QIC contractor, First Coast Service Options, Inc. (FCSO). A request form is located on page 56 at the back of this publication.

FCSO will begin processing these reconsiderations on November 15, 2006 for the North jurisdiction, which includes: Alaska, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, **Ohio**, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Kansas, Nebraska, South Dakota, North Dakota, Wyoming, Montana, Idaho, Washington, Oregon, California, Nevada, Arizona, Utah, Hawaii, Guam, Northern Mariana Islands, and American Samoa. The address to send the QIC reconsiderations to will be:

First Coast Service Options, Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

Any additional documentation, new information or medical evidence that may assist the QIC in reevaluating the claim(s) should be attached to the written reconsideration request. If no additional information is submitted, a decision will be made based on the documentation contained in the AC's redetermination case file.

NOTE: To aid in the processing of your request and to avoid significant delays, a copy of the redetermination letter should accompany your reconsideration request.

Reconsideration requests for services rendered in **West Virginia** will continue to be handled by Q2A at the following address:

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

Reconsideration request forms can be found on our Web site at http://www.Palmettogba.com/boh (Ohio) or http://www.Palmettogba.com/bwv (West Virginia).

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Home Health Consolidated Billing Enforcement: Annual Update of HCPCS Codes

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2007. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Key Points

CR 5356 provides the annual HH consolidated billing update effective January 1, 2007. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing on January 2, 2007.

Table 1: Non Routine Supplies

HCPCS Code	Description	Action	Replacement HCPCS Code being Replaced
A4213	Syringe, Sterile, 20 CC or Greater	Add	
A4215	Needle, Sterile, Any Size, Each	Add	

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HCPCS Code	Description	Action	Replacement HCPCS Code being Replaced
A4348	Male External Catheter with Integral Collection Compartment, Extended Wear, Each (e.g., 2 per month)	Delete	
A4359	Urinary Suspensory without Leg Bag	Delete	
A4244	Alcohol or Peroxide, per Pint	Add	
A4245	Alcohol Wipes, per Box	Add	
A4246	Betadine or Phisohex Solution, per Pint	Add	
A4247	Betadine or Iodine Swabs/Wipes, per Box	Add	
A4461	Surgical Dressing Holder, Non-reusable, Each	Add	Replaces code: A4462
A4462	Abdominal Dressing Holder, Each	Delete	Replacement code: A4461 and A4463
A4463	Surgical Dressing Holder, Reusable, Each	Add	Replaces code: A4462
A4932	Rectal Thermometer, Reusable, Any Type, Each	Add	
A6412	Eye Patch, Occlusive, Each	Add	

Table 2: Therapies

CPT Code	Description	Action	Replacement CPT Code being Replaced
97020	Application Microwave	Delete	Replacement Code: 97024
97024	Application of a Modality to One or More Areas: Diathermy (e.g., Microwave)	Redefine	Replaces code: 97020
97504	Orthotic(s) Fitting and Training, Upper Extremity(ies), Lower Extremity(ies), and/or Trunk, Each 15 Minutes	Delete	Replacement code: 97760

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CPT Code	Description	Action	Replacement CPT Code being Replaced
97520	Prosthetic Training, Upper and/or Lower Extremity(ies), Each 15 Minutes	Delete	Replacement code: 97761
97703	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Delete	Replacement code: 97762
97760	Orthotic(s) Management and Training (Including Assessment and Fitting when not Otherwise Reported), Upper Extremity(s), Lower Extremity(s) and/or Trunk, Each 15 Minutes	Add	Replaces code: 97504
97761	Prosthetic Training, Upper and/or Lower Extremity(s), Each 15 Minutes	Add	Replaces code: 97520
97762	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Add	Replaces code: 97703

Additional Information

For complete details regarding this CR please see the official instruction issued to your Medicare FI, carrier, A/B MAC, DMERC, RHHI, or DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1082CP.pdf on the CMS Web site.

A complete historical listing of codes subject to HH consolidated billing can be found at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp on the CMS Web site.

To review the Medicare regulations discussed in this article see the Medicare Claims Processing Manual Chapter 10, Section 10.1.25 at http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf on the CMS Web site.

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

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Processing All Diagnosis Codes Reported on Claims

Provider Action Needed

Impact to You

Effective, at the earliest, July 1, 2007, the carrier standard system for Medicare will automatically process all diagnosis codes that you submit on your claims.

What You Need to Know

CR 4276, the second phase in the implementation of the Negotiated Rulemaking agreement to automatically consider all diagnosis codes reported on claims, includes finalization of the requirements and coding development for the standard system used by Medicare carriers.

What You Need to Do

Make sure that your billing staffs are aware of these changes that allow eight diagnosis codes on Medicare claims effective, at the earliest, July 1, 2007.

Background

While the American National Standards Institute (ANSI) 837P 4010A allows the reporting of up to eight diagnosis codes in the 2300 loop, the Medicare carrier standard system uses only the first four diagnosis codes when processing HIPAA format claims. Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determination.

In CR 4276, from which this article is taken, CMS is requiring that (effective no earlier than July 1, 2007) the Medicare carrier standard system capture and process all diagnosis codes that are reported, up to the maximum of eight, on any claim (both electronic and paper) processed.

Additional Information

You can find more information about the application of all diagnosis codes reported in processing carrier claims by viewing CR 4276 at http://www.cms.hhs.gov/Transmittals/downloads/R1095CP.pdf on the CMS Web site.

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

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Drug/Radiopharmaceutical Not Otherwise Classified Codes National Drug Code Number to be Required: New Requirement

Effective January 1, 2007, when a "not otherwise classified" or "unlisted" HCPCS procedure code is submitted [J3490, J3590, J7599, J7699, J9999, A4641, A9699, and/or A9700], the National Drug Code (NDC) number must be in block 19 or on an attachment to the CMS-1500 claim form. For electronic claims, this information must be provided in the documentation record.

The name and dosage is still required in block 19 of the CMS-1500 claim form or in the documentation record for electronic claims.

Services submitted without the NDC number and name & dosage will be rejected. Rejected claims do not have appeal rights and must be submitted as new claims.

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Competitive Acquisition Program (CAP) for Part B Drug: Appeals

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5207, which instructs local Medicare carriers and the CAP designated carrier how to execute the appeals process within the unique requirements of CAP. Please note that the CAP claims processing arrangement is **not the same** as the standard Part B claims processing routine.

What You Need to Know

CR 5207 provides additional information and instructions for the implementation of the CAP pertaining to the CAP appeals and dispute resolution process. This is not a stand-alone CR. It builds on previously published related CAP CRs which include: CRs 4064, 4306, 4309, and 4404. The links to those CRs and the related Medicare Learning Network (MLN) articles are provided in the *Additional Information* section below.

What You Need to Do

See the *Background* section of this article and the information in CR 5207 for further details regarding these special CAP appeals requirements and delivery of dispute resolution services.

Background

Section 303 (d) of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals ("drugs") not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. A participating CAP physician will submit a claim for drug administration to the Medicare local carrier. An approved CAP vendor will submit a claim for the drug product to the CAP Medicare designated carrier.

Appeal Process for CAP Drug Claims

As mentioned above, the CAP claims processing arrangement departs from the standard Part B claims processing routine. Specifically, the CAP uses a local carrier's determination about the physician's drug administration claim that is associated with a CAP drug's claim as an indicator of whether a CAP vendor's matching drug claim should be paid. Therefore, if a local carrier denies the physician's drug administration claim that is to be matched to a CAP vendor's drug claim and causes the vendor's CAP drug claim to deny, the appeals process for the vendor's drug claim's denial must begin with the local carrier that denied the claim. In this situation, in order to pursue an appeal of a denied CAP drug claim, the approved CAP vendor becomes a party to the appeal of a denied drug administration claim filed by a participating CAP physician with the local carrier.

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If a CAP vendor's drug claim has been denied because there is no matching participating CAP physician claim on file with the local carrier, the Medicare designated carrier will deny the claim and will suppress appeal rights if there is still no matching drug administration claim after 90 days. The remittance notice will instruct the approved CAP vendor that it may request a reopening. In this case, if the approved CAP vendor accepts the designated Medicare carrier's offer and requests a reopening, the designated carrier will call the participating CAP physician to encourage the physician to file the drug administration claim. If the participating CAP physician does not file the claim, the designated Medicare carrier will engage in dispute resolution activities which may result in a recommendation to terminate the participating CAP physician's involvement in CAP.

The Medicare designated carrier will use group code **CO** for claims that are denied because the participating CAP physician has not filed his/her claim, will return the following messages:

- Medicare Summary Notice (MSN) – 16.34 – "You should not be billed for this service. You do not have to pay this amount."
- Remark code N211 – "You may not appeal this decision."

These messages are provided in addition to MSN message 21.21 and Remittance Advice (RA) reason code 107 for these claim denials. (See CR 4064, Business Requirement (BR) 4064.9.2.1, link provided below.)

Additional Information

CR 5207 adds sections 100.9-100.94 to Publication 100-04, the *Medicare Claims Processing Manual*, Chapter 17, "Drugs and Biologicals for CAP." CR 5207 is the official instruction issued to your Medicare carrier regarding changes mentioned in this article. CR 5207 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R1076CP.pdf on the CMS Web site.

CR 4064, dated December, 9 2005, "Competitive Acquisition Program (CAP) for Part B Drugs" is located at http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf on the CMS Web site. The related MLN article, MM4064 "Competitive Acquisition Program (CAP) for Part B Drugs" can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf on the CMS Web site.

CR 4306, dated February 6, 2006, "MCS Screen Expansion for the Prescription Order Number for the Competitive Acquisition Program (CAP) for Part B Drugs to be Developed Over the July 2006 and October 2006 Release, With Final Implementation on October 2, 2006" is available at the following link http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf on the CMS Web site.

CR 4309, dated February 17, 2006, "Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs" can be found at the following link http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf on the CMS Web site.

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The related MLN article, MM 4309 "Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs" can be reached at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf on the CMS Web site.

CR 4404, dated April 28, 2006 "Competitive Acquisition Program (CAP) for Part B Drugs Physician Election" is located at http://www.cms.hhs.gov/transmittals/downloads/R932CP.pdf on the CMS Web site. MM 4404, "Competitive Acquisition Program (CAP) for Part B Drugs Physician Election" the related MLN article can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf on the CMS Web site.

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Ambulance Inflation Factor: Calendar Year 2007

Provider Action Needed

This article is for your information only. It provides the Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2007. The AIF for CY 2007 is 4.3%.

Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services. The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The Ambulance Inflation Factor (AIF) updates payments annually and is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

The AIF for calendar year (CY) 2007 will be 4.3%. The following table displays the AIF for CY 2007 and for the previous 4 years.

Ambulance Inflation Factor by Calendar Year	
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

Additionally, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) will have a baseline "floor" amount.

Payment will not be less than this "floor," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule to calculate a regional conversion factor and a regional mileage payment.
Some key issues related to the AIF include:

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

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Payments Based on Blended Methodology
During the five-year transition period, your payments are based on a blended methodology. For CY 2007, this blend will be 20% regional ground base rate and 80% national ground base rate.

Before January 1, 2007, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost/charge portion. Then, these two amounts were added together to determine each provider or supplier's total payment amount. As of January 1, 2007, the total payment amount for air ambulance providers and suppliers continues to be based on 100% of the national ambulance fee schedule, while the total payment amount for ground ambulance providers and suppliers will be based on either 100% of the national ambulance fee schedule or 80% of the national ambulance fee schedule and 20% of the regional ambulance fee schedule.

Part B Coinsurance and Deductible Requirements
Part B coinsurance and deductible requirements apply.

Additional Information
You can find more information about the ambulance inflation factor by going to CR 5358, located at http://www.cms.hhs.gov/Transmittals/downloads/R1102CP.pdf on the CMS Web site. There you will find updated Medicare Claims Processing Manual (100-04), Chapter 15 (Ambulance), Section 20.6.1 (Ambulance Inflation Factor (AIF)) as an attachment to that CR.

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

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Infrared Coagulation of Hemorrhoids

Hemorrhoids are symptomatic abnormalities of the fibrovascular cushions within the anal canal. The three cardinal locations for these cushions are left lateral, right antero-lateral and right postero-lateral quadrants. Symptoms include pain, bleeding and prolapse.

Internal hemorrhoids are located above the dentate line, while external hemorrhoids are located below it. Internal hemorrhoids are graded according to symptoms.

- Grade I - Prominent hemorrhoids without prolapse
- Grade II - Prolapse with Valsalva that is spontaneously reduced
- Grade III – Prolapse with Valsalva requiring manual reduction
- Grade IV - Chronic prolapse with ineffective manual reduction

Infrared coagulation (IRC) is a reasonable and necessary outpatient or office procedure only when used for treating symptomatic Grade I and Grade II internal hemorrhoids that do not respond adequately to conservative treatment. An accepted practice is to treat one quadrant per session, but only one service is reimbursed per 90-day global period, regardless of the number of treatment sessions. When multiple IRC fails to adequately manage the problem, another method of treatment with proven high success rates such as rubber band ligation or injection sclerotherapy is appropriate.

- CPT code 46934: Destruction of hemorrhoids, any method; internal
- ICD-9 code 455.2: Internal hemorrhoids with other complication

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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, February 7, 2007	Best Western Columbus North 888 E. Dublin Granville Road Columbus, Ohio 43229	9:00 a.m. – 12:00 p.m.
Wednesday, May 16, 2007	Holiday Inn 5513 Milan Rd. Sandusky, Ohio 44870	9:00 a.m. – 12:00 p.m.
Wednesday, August 1, 2007	Holiday Inn/Muskingum Valley Conference Center 4645 East Pike Zanesville, Ohio 43701	9:00 a.m. – 12:00 p.m.

West Virginia Seminars

Date	Location	Time
Wednesday, February 28, 2007	Cedar Lakes Conference Center HC 88, Box 21 Ripley, WV 25271	9:00 a.m. - 12:00 p.m
Wednesday, May 30, 2007	Brier Inn 540 N. Jefferson St. Lewisburg, WV 24901	9:00 a.m. - 12:00 p.m.
Wednesday, August 29, 2007	Clarion Hotel & Conference Center 233 Lowe Drive Shepherdstown, WV 25443	9:00 a.m. - 12:00 p.m..

Registration:

To Register for a seminar please 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.

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

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Ambulance Supplier Claims: Carrier Jurisdiction

Impact to You

Effective for claims processed January 1, 2008, and later, a claim for an ambulance service furnished by a supplier must be filed with the carrier or A/B MAC having jurisdiction for the "point of pickup" (POP).

What You Need to Know

Effective April 1, 2007, each carrier will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction. For dates of service of January 1, 2008, or later, ground and air ambulance supplier claims for a point of pick-up not rendered in the carrier's (or A/B MAC's) jurisdiction will be returned to the supplier as "unprocessable".

What You Need to Do

Be sure your staff knows to file Medicare claims with the carrier or A/B MAC having jurisdiction for the POP to assure prompt and accurate payment.

Background

The Medicare claims filing jurisdiction rule for ambulance services has been that an ambulance must file the claim with the carrier or A/B MAC having jurisdiction for where the service was furnished. When the ambulance fee schedule policies and systems changes were being developed, most carriers interpreted this rule to mean that a claim for an ambulance service must be filed with the carrier or A/B MAC having jurisdiction for the area where the vehicle is garaged or hangered. When the ambulance fee schedule was implemented beginning January 1, 2000, CMS determined that this de facto interpretation of the claims filing jurisdiction rule would not be changed during the fee schedule transition period which was completed on January 1, 2006. (See Program Memorandum (PM) AB-00-88, Change Request (CR) 1281, dated September 18, 2000 which was re-issued as PM AB-01-185 dated December 14, 2001. CR1281 can be found at the following link on CMS' Web site at http://www.cms.hhs.gov/Transmittals/Downloads/AB01185.pdf.)

Currently all ambulance services are paid under the fee schedule which is based on the location from which the beneficiary is transported, i.e., the "point of pickup" (POP). Because the basis for payment under the fee schedule is based on the POP, it is reasonable for the claims filing jurisdiction rule to also be based on the POP.

Changing the claims filing jurisdiction to the POP will ensure jurisdictional congruence between the policies for payment and claims filing. It will additionally ensure that the ambulance supplier meets the State and local requirements where the service was furnished, which was the original intent of the claim filing jurisdiction rule. This change will:

- Bring administrative practice into congruence with the longstanding regulatory standards at 42 C.F.R. § 410.41;
- Avoid having Federal administrative practice undercut appropriate State and local regulatory standards; and
- Promote an appropriate level of service for all Medicare beneficiaries.

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For dates of service of January 1, 2008, or later, ground and air ambulance supplier claims for a point of pick-up not rendered in the carrier's (or A/B MAC's) jurisdiction will be returned to the supplier as "unprocessable", accompanied by the following remittance advice message:

- "N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the Medicare contractor to process this claim/service through the CMS Web site at http://www.cms.hhs.gov."

Carriers and A/B MACs will not apply this rule to:

- Ambulance claims submitted to the carrier that processes Indian Health Service ambulance claims, or
- Any future ambulance demonstration claims unless CMS so directs that this policy applies.

As a consequence of changing the claims filing rule to the POP, ambulance suppliers (including those who operate in multiple States) **must be enrolled with the carrier in each jurisdiction** where they furnish services to Medicare beneficiaries. This is the case even if that supplier does not garage or hanger its vehicles in each State in which the supplier operates (required by 42 C.F.R. § 410.41 located on CMS' Web site at http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_41.pdf).

Note: As early as April 1, 2007, each carrier or A/B MAC will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction.

Exception: Where the POP is outside the United States, the claim for an ambulance service furnished by a supplier must be filed in accordance with the instructions in Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 1 § 10.1.4.1. Carrier jurisdiction is defined in Publication 100-04, Chapter 1 § 10.1.4.2. These instructions can be found on CMS' Web site at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

Additional Information

CR 5203 is the official instruction issued regarding changes mentioned in this article and may be found on CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1100CP.pdf.

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

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Clinical Diagnostic Services Purchased Outside of the Local Carrier's Jurisdiction: Reporting NPI on Physician Claims

Background

This article relates to Change Request (CR) 5289, in which the Centers for Medicare & Medicaid Services (CMS) provides specific instructions for physicians to modify their current reporting guidelines and requires physicians to begin **reporting, as of May 23, 2007, a National Provider Identifier (NPI) on claims for clinical diagnostic services purchased outside of the local carrier's jurisdiction**. Previously CMS instructed physicians to report their provider identification number (PIN) on claims when billing for clinical diagnostic services purchased outside of the local carrier's jurisdiction. (See Change Request 3630, Transmittal 415, issued on December 23, 2004 at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3630.pdf on CMS' Web site).

As of May 23, 2007, physicians must begin using their NPI to bill the local carrier for a clinical diagnostic service purchased outside of the jurisdiction of the local carrier or A/B MAC. As of May 23, 2007, remember the following:

- When reporting the 2400 PS1 segment (Purchased Service Information) of the ANSI X12 837 electronic claim format, version 4010A, the billing physician must report their NPI.
- When submitting paper claims, physicians must report their NPI for both the purchased portion of the test and the portion of the test that they performed.
- Physicians may no longer report a PIN after May 22, 2007.

Prior to May 23, 2007, physicians may report the PIN, the NPI, or both PIN and the NPI.

Additional Information

For complete details, please see the official instruction issued to your Medicare carrier or A/B MAC, regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R243OTN.pdf on CMS' Web site.

To learn more about the NPI and how to apply for one, visit http://www.cms.hhs.gov/NationalProvIdentStand/ on CMS' Web site.

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

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

Provider Action Needed

This article is based on Change Request (CR) 5384, which announces the changes that will be included in the January, 2007 release of the edit module for clinical diagnostic laboratory NCDs.

Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. The Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its shared systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective January 1, 2003.

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the Medicare Claims Processing Manual (Pub. 100-04), Chapter 16, Section120.2, available at *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf* on CMS' Web site.)

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

CR 5384 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after January 1, 2007.
CR 5384 specifically announces the addition of the following ICD-9-CM code(s):

- **V58.83 (Encounter for therapeutic drug monitoring)** to the list of 1) ICD-9-CM codes covered by Medicare for **the Prothrombin Time (190.17) NCD and** 2) ICD-9-CM codes covered by Medicare for **the Partial Thromboplastin Time (190.16) NCD**;
- **783.0 (Anorexia) and 793.99 (Other nonspecific abnormal findings on radiological and other examinations of body structure)** to the list of ICD-9-CM codes covered by Medicare **for the Thyroid Testing (190.22) NCD**; and
- **995.20 (Unspecified adverse effect of unspecified drug, medicinal and biological substance)** to the list of ICD-9-CM codes covered by Medicare for **the Fecal Occult Blood Test (190.34) NCD**.

CR 5384 also modifies the descriptor **for CPT code 87088 in Urine Culture, Bacterial NCD (190.12**) to read "Culture, bacterial; with isolation and presumptive identification of each isolates, urine".

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Additional Information

For complete details, please see the official instruction issued to your carrier, FI, or A/B MAC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1093CP.pdf on CMS' Web site.

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Outpatient Therapy Cap Exceptions: Clarifications

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed Financial limitations on Medicare covered therapy services (therapy caps), that were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were re-implemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary.

Review of this exception process

Section 1833(g)(5) of the Social Security Act provides that, **for services provided during calendar year 2006**, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception Processes fall into two categories: 1) **Automatic** Process Exceptions, or 2) **Manual** Process Exceptions. Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if:

- they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual,* Publication 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap for 2006; or,
- meet specific criteria for exception, in addition to those listed in the *above referenced Manual*, when the Medicare contractor believes (based on the strongest evidence available) that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

The clarifications to questions generated from CR 4364. Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual,* Pub. 100-04, Chapter 5, (as revised by CR4364)
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment

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days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted in 2006.

3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request in 2006.
4. Must reply as soon as practicable to a request for exception. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that **may or may not be on the list** in the *Medicare Claims Processing Manual* in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs
9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for re-evaluation **only** because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.
13. Will, on pre or post pay medical review, require clinicians to write Progress Reports at least during each Progress Report Period. Note that required elements of the Progress Report that are written into the Treatment Notes or in a Plan of Care acceptably fulfill the requirement for a Progress Report. In these instances, a separate Progress Report is not required.
14. Will require, on pre or post pay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.

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15. Will continue to use Medicare Summary Notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."
16. Will continue to enforce Local Coverage Determinations (LCDs).

Final Note: You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.

Additional Information

You can find more information about outpatient therapy cap exceptions by going to CR 5271, issued in 3 transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The *Medicare Claims Processing Manual,* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation); (This will be at http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf)
- The *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception from the Uniform Dollar Limitation ("Therapy Cap")). (This will be at http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf); and,
- The *Medicare Benefit Policy Manual,* Chapter 15, Section 220.3 (Documentation Requirements for Therapy Services.) This is available at http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf on the CMS site.

These manual revisions include numerous additional changes clarifications.

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

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Repeat or Duplicate Services on the Same Day

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

Many providers and billing departments re-file claims without allowing sufficient time for the original claim to process. One submission is all that is required. If you have not received payment after 30 days and are concerned about your payment, contact Palmetto GBA via the toll-free Provider Contact Center at 1-877-567-9232 to check the status of a claim 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. Palmetto GBA can "reopen" these claims, at your request. Please write to:

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

Or you may call 1-866-308-5441.

Minor claim corrections can also be reopened by calling our telephone reopening line at 1-866-308-5441 Monday-Friday 9 A.M. to 12 P.M. and 1 P.M. to 3 P.M.

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.
- Use the Days/Units Field. Submit services on one claim using the Days/Units field.

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

Example:
Patient receives two chest x-rays on October 1, 2005, 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.

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Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	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.

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
10/1/05	28010-T1	1
10/1/05	28010-T3	1

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

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

Example:
Patient receives three chest x-rays on October 1, 2005, 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
10/1/05	71020	1
10/1/05	71020-76	2

OR submit as:

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Date of Service	CPT Code	Days/Units
10/1/05	71020	3

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

Example:
Patient receives two EKGs on October 1, 2005. The first EKG is taken at 10:00 a.m. and Dr. A performs the interpretation. The second EKG is taken at 1:30 p.m. and Dr. B performs the interpretation.

Submit as:
Claim #1 – Dr. A

Date of Service	CPT Code	Days/Units
10/1/05	93010	1

Claim #2 – Dr. B

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	93010-77	1

- **CPT Modifier 91 – "Repeat clinical diagnostic laboratory test":** It may be necessary to repeat the same laboratory test on the same day to obtain multiple test results. CPT modifier 91 should be used in this case. This modifier may not be used when tests are repeated to confirm 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
10/1/05	82746	1
10/1/05	82746-91	1

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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 Contact Center at 1-877-567-9232.

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

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

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

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Local Coverage Determination Updates

LCD	Change	Effective Date
Ocular Photography & Ophthalmoscopy 2001-52LR14	Addition of ICD-9 codes 190.0-190.9, 224.0-224.9 and 372.00 – 372.9 as supporting medical necessity for CPT code 92285.	11/01/06
Cancer Chemotherapy & Chemotherapeutic Agents 2002-29LR28	Addition of ICD-9 codes 206.10 and 206.11 as supporting medical necessity of HCPCS code J9025 (Azacitidine). Addition of HCPCS code J9999 (Panitumumab; Vectibix™) with ICD-9 codes 153.0 - 153.9, 154.0, 154.1, and 154.8 as supporting medical necessity.	11/01/06 10/01/06

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Medicare Part B Refund *and* Overpayment Form

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

Provider Information
(Must be Completed)

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

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

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

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

Medicare Secondary Payer Reason For Overpayment

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

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

Medicare Secondary Payer (MSP)

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

Secondary Insurance:

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

Reason For Overpayment/Refund

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

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

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

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

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

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Medicare Opt Out Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) Bonus Program

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

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

_____

Signature: _____

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

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

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

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

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

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

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

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

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Redetermination Request for Medicare Part B Claims

For Ohio & West Virginia

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

If you have received a Medicare Redetermination on this claim DO NOT use this form to request further appeal. If your redetermination decision is dated after 1/1/06, follow instructions in your decision letter for further appeal to the Qualified Independent Contractor or use the appropriate reconsideration request form found on our Web site at http:\\www.PalmettoGBA.com.

If your redetermination decision is dated prior to 1/1/06, you may still request a carrier hearing officer hearing. Use the form found on our Web site at http:\\www.PalmettoGBA.com.

General Information

Patient's name _____

Health Insurance Claim (HIC) number _____

Date of initial determination _____

CPT code(s) _____

ICD-9 code(s) _____

Performing provider number _____

Billing provider number _____

Phone number _____

Date of service _____

This is an appeal for:

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

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

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

Reason for request: _____

_____

_____

_____

Requestor (signature required): _____ Date: _____

Address: _____

_____

_____

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

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RECONSIDERATION REQUEST FORM - QIC NORTH (Ohio)

(Effective for Redeterminations processed on and after November 6, 2006.)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must include the bolded information but to help us serve you better, please include a copy of the redetermination notice and identify the claim number with your reconsideration request.

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

1. Name of Beneficiary: _____

2 a. Medicare Number: _____

b. Claim Number: _____
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

3. Provider Name and Number: _____

4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative

5. Address of Person Appealing:

6. Item or service you wish to appeal:

7. Date of service: From _____ /_____ /_____ To _____ /_____ / _____

8. Does this appeal involve an overpayment? ☐ Yes ☐ No

9. Why do you disagree? Or, what are your reasons for your appeal? (Attach additional pages, if necessary.)

10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:
☐ Medical Records ☐ A Copy of the Claim ☐ Treatment Plan
☐ Certificate of Medical Necessity ☐ Office Notes / Progress Notes

11. Printed Name of Person Appealing:

12. Signature of Person Appealing: _____ Date: _____

13. Phone Number of Person Appealing: _____

Contractor Number: 00883

Palmetto GBA –Ohio Medicare Part B Carrier (Carrier 00883)
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 567-9232
A CMS Contracted Intermediary and Carrier

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MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

Reconsideration Request Form - QIC East (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. **To help us serve you better, please include a copy of the redetermination notice with your reconsideration request.**

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

1. Name of Beneficiary: _____
2. Medicare Number: _____
3. Provider Name and Number: _____
4. Person Appealing: Beneficiary Provider of Service Representative
5. Address of Person Appealing:_____
   _____
6. Item or service you wish to appeal: _____
7. Date(s) of service: ____/____/____ TO ____/____/____
8. Does this appeal involve an overpayment: Yes No
9. Why do you disagree? Or, what are your reasons for your appeal? (Attach additional pages, if necessary.)
   _____
   _____
10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:

    Medical Records A copy of the Claim Treatment Plan

    Certificate of Medical Necessity Office Notes / Progress Notes

11. Printed Name of Person Appealing: _____
12. Signature of Person Appealing: _____ Date: _____

Appeal Number: _____ Contractor Number: 00884
(The appeal number can be found on the redetermination decision letter after "*In Any Inquiry Refer To"*)

Palmetto GBA –West Virginia Medicare Part B Carrier (Carrier 00884)
Post Office Box 182934 * Columbus, Ohio * 43218-2394
Beneficiary Service Center: (800) MEDICARE * Provider Service Center: (877) 567-9232
A CMS Contracted Intermediary and Carrier

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Call Center
1-877-567-9232 (Toll-Free)
FAX (614) 473-6805

TTY 1-877-391-9739

Provider Enrollment Support Line
1-866-308-5439

Electronic Data Interchange (EDI) Technical Support
1-866-308-5438

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

To request a Medicare Provider Education meeting/ seminar at no cost to you, complete and fax the form located on the http://www.PalmettoGBA.com/boh (Ohio) or http://www.PalmettoGBA.com/bwv, select 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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