Take Advantage of Electronic Funds Transfer (EFT) to Receive Your Medicare Payments!

Electronic Funds Transfer (EFT) allows your financial institution to deposit your Medicare payments into accounts designated by you. There is no charge by Medicare for this service. These deposits will appear on your bank statements. Medicare does not use EFT to withdraw money from your account.

Benefits of Electronic Funds Transfer:

- Faster receipt of your payments
- Avoid the possibility of your checks being lost or delayed in the mail
- Increased security for your office (paper checks can be stolen)
- Helps save Medicare dollars for paper, printing, and postage associated with hardcopy payment

To take advantage of this service and begin receiving your payments electronically, please complete the EFT application form. In addition to the application, you must include a voided check to ensure that Medicare has the correct American Banking Association (ABA) routing number. Your application cannot be processed without the voided check.

You can also obtain an application and further details from the Palmetto GBA Web site:

Line of Business	**Web site**	**Return the form to:**
Ohio Part B	http://www.PalmettoGBA.com/boh/forms	Provider Enrollment – EFT Analysts Palmetto GBA OH/WV P O Box 182933 Columbus OH 43218-2933
West Virginia Part B	http://www.PalmettoGBA.com/bwv/forms	Provider Enrollment – EFT Analysts Palmetto GBA OH/WV P O Box 182933 Columbus OH 43218-2933

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2008 Participation Enrollment Information

Soon, Palmetto GBA will mail important information to you regarding participation in Medicare and useful resources for your practice. We anticipate that the CD-ROM will be mailed in November 2007 and will contain the following:

- Cover letter
- Fact Sheet
- Resource & contact listing
- CY 2008 Medicare Participation Enrollment announcement and agreement

Note: Fee schedule information for Ohio, South Carolina and West Virginia will only be available on our Web site at http://www.PalmettoGBA.com/boh/fees (Ohio), http://www.PalmettoGBA.com/bwv/fees (West Virginia) or http://www.PalmettoGBA.com/bsc/fees (South Carolina).

As a further bonus, the CD-ROM will contain a great deal of information that will not be available in the requested print version including:

- CMS-1500 Interactive Claim Form
- CMS 855 application information
- Electronic Data Interchange (EDI) information
- Electronic Funds Transfer (EFT) information
- Claim submission
- Deductible/co-insurance rates
- Deleted, invalid and non-covered codes
- Much more!

We will distribute the information on a CD-ROM so that you will be able to:

- Print paper copies as needed
- View the portions that are applicable to your practice
- Copy information from computer to computer
- Store for easy retrieval

The CD-ROM should be readable by any system with Microsoft Windows or Macintosh OS 8 or greater. If you do not have a computer or if your computer lacks a CD-ROM drive, you can request a printed copy at no charge by returning the detachable post card that will accompany the CD-ROM.

Further information regarding the 2008 Participation Enrollment and Physician Fee Schedule will be available in future editions of the *Medicare Advisory* and on our Web site,
http://www.PalmettoGBA.com/boh (Ohio),
http://www.PalmettoGBA.com/bwv (West Virginia) or
http://www.PalmettoGBA.com/bsc (South Carolina).

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You may also call the Palmetto GBA Provider Contact Center at 1-877-567-9232.

In addition, you can register to receive e-mail notifications informing you when our Web site has been updated. This can be done by going to
http://www.PalmettoGBA.com/boh (Ohio),
http://www.PalmettoGBA.com/bwv (West Virginia) or
http://www.PalmettoGBA.com/bsc (South Carolina), clicking on E-mail Updates and following the instructions for registering.

Interest Payment on Clean Claims Not Paid Timely

This rate is determined by the Treasury Department on a 6-month basis, effective every January 1 and July 1. For the correct rate, providers may access the Treasury Department Web page at
http://www.treasurydirect.gov/govt/rates/tcir/tcir_opdprmt2.htm.

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Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians: Contains rural health services information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the Deficit Reduction Act of 2005. The primary audience includes rural health providers, suppliers, and physicians. (February 2007); Available in hard copy, CD Rom, and downloadable formats.

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals: Offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals. (July 2007); Available in hard copy, CD Rom, and downloadable formats.

Companion Facilitator's Guide – To The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals: Includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program, including instructions for facilitators, a customization guide, two PowerPoint presentations with speaker notes, pre- and post-assessments, master assessment answer keys, and evaluation tools. (January 2007) Available in hard copy, CD Rom, and downloadable formats.

Physicians' Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services: Explains how Medicare helps pay for kidney dialysis and kidney transplant services under the fee-for-service program. (June 2007) Available in hard copy and downloadable formats.

Other Educational Tools

Medicare Learning Network Guidance Tool: Now available in CD ROM format and can be ordered through the Medicare Learning Network, product ordering page. This playable CD will streamline your search to find the most relevant and up-to-date links or URLs for national provider educational materials. A tutorial will show you how to use the Guidance Tool to locate a new link (URL), refine your search, view, download and order educational articles, brochures, fact sheets, web-based training courses, worksheets and videos. Additionally, the MLN Guidance Tool will demonstrate by example how to navigate through sections of CMS' Medicare Learning Network. (January 2007); Available in CD ROM format.

Medicare Preventive Services Bookmark: Lists the preventive services and screenings covered by Medicare and provides a message that encourages health care professionals to talk with their Medicare patients about these preventive services and encourage them to take advantage of these potentially life saving benefits. This product is appropriate for distribution at health care professional conferences, provider outreach and education activities, and other appropriate types of provider/supplier events. (January 2007) Available in hard copy and downloadable formats.

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Quick Reference Information: Medicare Preventive Services: A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services. (May 2007); Available in hard copy and downloadable formats.

Quick Reference Information: Medicare Immunization Billing (Flu, PPV, and HBV): A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare billing information for the influenza, Pneumococcal, and hepatitis B vaccines and their administration. (October 2006); Available in hardcopy and downloadable formats.

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals: An educational video program that provides an overview of coverage criteria for Medicare preventive benefits. This program can be viewed individually or as part of an education session at a conference or other provider meeting. (The program is 75 minutes in length and approved by CMS for continuing education credits for successful completion.)

Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart: Provides Medicare claims processing information related to SNF spells of illness. (January 2007); Available in downloadable format only.

Brochures

Changes in Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs): Addresses the CMS multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. (May 2007)

Diabetes-Related Services: This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. (August 2007)

Fact Sheets

Critical Access Hospital Program: Covers information related to the Critical Access Hospital Program. (March 2007)

Federally Qualified Health Center Fact Sheet: Covers the Federally Qualified Health Center (FQHC) benefit under Medicare. (March 2007)

Implementation of the UB-04: Reviews the new UB-04 paper claim form which is only accepted from institutional providers excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk. (May 2007); Available in downloadable format only.

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Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet: This fact sheet provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion. (March 2007)

Medicare Disproportionate Share Hospital Fact Sheet: Covers the basics of the Medicare Disproportionate Share Hospital (DSH). (August 2007)

Medicare Physician Fee Schedule Fact Sheet: Provides general information about the Medicare Physician Fee Schedule. (January 2007)

Medicare Secondary Payer Fact Sheet: Provides a general overview of the Medicare Secondary Payer provision for individuals involved in the admission and billing procedures at provider, physician and other supplier settings. (June 2007)

Rural Health Clinic Fact Sheet: Covers the basics of the Rural Health Clinic (RHC) Program. (June 2007)

Rural Referral Center Fact Sheet: Covers the basics of the Rural Referral Center (RRC) Program. (March 2007)

Web Based Training Programs

CMS Form 1450: Provides information that will allow you to file Medicare Part A claims accurately and reduce your chances of receiving unprocessable rejections. (January 2007)

CMS Form 1500: Provides information that will allow you to file Medicare Part B claims accurately and reduce your chances of receiving unprocessable rejections. (May 2007)

Diagnosis Coding: Using the ICD-9-CM: Teaches you how to select accurate diagnosis codes from the ICD-9-CM volumes and how to use diagnosis codes correctly on Medicare claim forms. (May 2007)

Medicare Fraud and Abuse: Teaches you how to identify Medicare fraud and abuse. You will also learn what safeguards to use to protect yourself against fraud and abuse and what liability and penalties you could face if you commit fraud or abuse. (April 2004)

Outpatient Code Editor (OCE): Useful for physicians and other health care professionals. This course addresses the OCE in Medicare's Fiscal Intermediary Standard System, which processes outpatient claims. (January 2007)

Medicare Preventive Services Series: Part 1 Adult Immunizations: This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration. (Updated September 2007)

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National Provider Identifier

Health Care Providers - Who are Sole Proprietors?: A sole proprietor/sole proprietorship is an individual and, as such, is eligible for a single NPI. Read more about Sole Proprietors and the NPI. (July 2007)

Health Care Providers - Who are Organizations?: Organization health care providers apply for NPIs as Organizations (Entity Type 2). Read more about Organization Providers and the NPI. (July 2007)

Tip Sheets -What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers: Interprets the recently released contingency guidance into helpful steps for providers. (May 2007)

National Provider Identifier Training Package: CMS has developed a Training package for NPI that will assist providers with self-education, as well as education of staff. This package is also useful to national and local medical societies for group presentations and training. The entire package will consist of five modules: General Information, Electronic File Interchange (EFI), Subparts, Data Dissemination and Medicare Implementation. Each Module consists of a PowerPoint presentation (with speaker's notes) and is designed to stand alone or can be combined with other Modules for a training session tailored to the particular audience.

Enrolling in Medicare: CMS has posted a document that will assist physicians in completing the CMS-855I, Medicare Provider Enrollment Application for Physicians and Non-Physician Practitioners. The document is available at http://www.cms.hhs.gov/Medicareprovidersupenroll/downloads/EnrollmentNPI.pdf.

Physician Quality Reporting Initiative (PQRI) Tool Kit

CMS has developed a "PQRI Tool Kit ~ Six Steps for Success" that will assist eligible professionals with successful reporting, as well as education of staff. This Tool Kit is also useful for group presentations and training programs. Currently, the Tool Kit consists of six educational resources (listed below). Each resource in the Tool Kit is designed to stand alone or can be combined with other resource for a training session tailored to the particular audience. The Tool Kit includes:

- **2007 PQRI Physician Quality Measures -** A numerical listing of all measures included in 2007 PQRI;
- **MLN Matters Article 5640- Coding & Reporting Principles -** A publication that introduces the coding and reporting principles underlying successful PQRI reporting;
- **2007 PQRI Code Master -** A numerical listing of all codes included in PQRI intended for incorporation into billing software;
- **2007 Coding for Quality Handbook -** A handbook that delineates coding and reporting principles and provides implementation guidelines for how to successfully report measures using clinical scenarios;

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- **2007 Data Collection Worksheets -** Measure-specific worksheets that walk the user step-by-step through reporting for each quality measure; and

- **2007 PQRI Measure Finder Tool and User Guide -** A tool designed to assist eligible professionals and their practice staff to quickly search for applicable measures and their detailed specifications.

Physician Quality Reporting Initiative (PQRI) PowerPoint Presentations

CMS has developed PowerPoint presentation modules that will assist eligible professionals with successful reporting, as well as education of staff. These PowerPoint presentation modules are also useful for group presentations and training programs.

Beneficiary Related News

MyMedicare.gov

As announced in last year's article, Medicare beneficiaries can access Medicare's free secure online service to view their Medicare information by registering for MyMedicare.com. At this site, they can access their personalized information about their Medicare benefits and services, and can:

View claim status (excluding Part D claims);

- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card;
- View eligibility, entitlement, and preventive services information;
- View enrollment information including prescription drug plans;
- View or modify their drug list and pharmacy information;
- View address of record with Medicare and Part B deductible status; and
- Access online forms, publications, and messages sent by CMS.

Registration is simple. Medicare beneficiaries should go to http://www.medicare.gov and click on the box in the upper left of the screen to sign up for **MyMedicare.gov.**

Additional Information

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

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National Provider Identifiers (NPIs): Rejection of Electronic Claim Status Requests

Impact to You

This article is based on Change Request (CR) 5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR 5726 specifically addresses changes around the processing of electronic claim status requests and the responses to such requests.

What You Need to Know

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number. This policy also applies to direct data entry (DDE) claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

What You Need to Do

No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers.)

Background

All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those, that do not, are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number, as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information

The official instruction, CR 5726, issued to your Medicare contractor can be found at http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.pdf.

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

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Medicare Participating Physicians Directory (MEDPARD)

The Ohio and West Virginia Medicare Participating Physicians Directory (MEDPARD) containing the listing of names, addresses, phone number, and specialties of all participating providers within the Medicare Part B Program may be accessed through the appropriate state's Web site at:

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

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

An updated listing of the most current MEDPARD information will be posted on these Web sites by February 1, 2008.

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 about the MEDPARD listing, please call Brenda Knox at 1-614-473-7169. 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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Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions

Impact to You

This article is based on Change Request (CR) 5606, which implements a process to enable the application of the Administrative Simplification Compliance Act (ASCA) enforcement review decisions made by non-Railroad (non-RR) Medicare Contractors to the same providers when they bill the Railroad (RR) Medicare Carrier (RMC).

What You Need to Know

Due to distribution of RR retirees, many providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and these providers have been allowed to continue to submit paper claims to the RMC. The same providers may also treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors. ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. By adding ASCA enforcement review decision information to the file sent from non-RR Medicare contractors to the RMC to share provider data, the RMC can apply decisions that providers are ineligible to submit paper claims to those same providers when they bill the RMC.

What You Need to Do

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

Background

The Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions including an exception that allows providers that submit fewer than 120 claims per year (no more than 10 claims per month or 30 claims per quarter) to Medicare to continue to submit paper claims. See the *Medicare Claims Processing Manual*, Chapter 24, Sections 90-90.6 at http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf.

Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

However, ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, are subject to ASCA Enforcement Review by each of those contractors.

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If a non-RR Medicare contractor 1) determines that a provider does not meet criteria which would permit that provider to continue to submit Medicare claims on paper and 2) notifies the provider that all paper claims submitted on or after a specific date will be denied, then that same decision is to be applied to that provider if submitting paper claims to the RMC even if that provider would not normally submit 10 or more paper claims to the RMC monthly.

If a provider reports that another Medicare contractor has reversed a decision that the provider is ineligible to submit paper claims, the RMC will ask that provider to submit a copy of the reversal letter from that contractor and to hold all new paper claims until such time as the RMC reviews the reversal letter and can advise the provider by letter that they can submit the paper claims.

Effective with the implementation date of CR 5606, the Medicare Claims System (MCS) maintainer that prepares the provider files for transfer to the RMC will add ASCA Enforcement Review information when that information is in the non-RR provider files used to prepare the report for the RMC. Once added to the file, information concerning ASCA Enforcement decisions made by the non-RR Medicare contractors (such as providers are ineligible to submit paper claims) will be accessible to the RMC so the same decisions can be applied to the same providers when they bill the RMC.

CR 5606 also updates the *Medicare Claims Processing Manual* to eliminate references to Claims Status and Coordination of Benefits (COB) Medicare HIPAA Contingency Plans and changes to reflect transfer of responsibility for Medigap claims to the COB contractor.

Additional Information

The official instruction, CR 5606, issued to Palmetto GBA regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1353CP.pdf.

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

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National Provider Identifier (NPI) Final Implementation: Medicare Fee for Service (FFS)

Impact to You

This article is based on CR 5728, which describes the policy change brought about as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions.

What You Need to Know

Once CMS ends the NPI contingency, the legacy number will NOT be permitted on any inbound electronic and outbound electronic transaction (there are exceptions to the 835 remittance advice (see CR 5452)). Medicare contractors will begin rejecting claims, electronic, including direct data entry, that contain legacy provider numbers for any primary provider instead of or in addition to the NPI number. The following HIPAA transactions are also affected:

- X12N 276/277 Claim Status Inquiry/Response – (see CR 5726 for details.)

- X12N 837 Coordination of Benefits (COB) – NPI only will be sent on the 837 coordination of benefits. Legacy numbers are not allowed. An exception will exist for claims that have not cleared the system by the date that CMS ends its NPI contingency plan. Such claims may contain the legacy number and, therefore, the COB transaction will also include the legacy number.

What You Need to Do

No later than May 23, 2008, providers should ensure that all HIPAA transactions sent to Medicare contractors contain only valid NPI numbers (no legacy provider numbers.)

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. The Centers for Medicare & Medicaid Services (CMS) began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only;
- Medicare legacy only; or
- NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee for

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service (FFS) established a contingency plan on April 20, 2007, that followed this guidance. CR 5728 directs Medicare contractors to begin rejecting HIPAA inbound claims when directed by CMS, if they contain legacy provider identifiers.

Since paper claims are not HIPAA transactions, these requirements do not apply to paper claims, however, providers should not submit legacy numbers on paper claims once CMS ends its NPI contingency plan.

Additional Information

The official instruction, CR 5728, issued can be found at
http://www.cms.hhs.gov/Transmittals/downloads/R1349CP.pdf.

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

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National Provider Identifier (NPI): Ordering/Referring and Attending/Operating/Other/Service Facility

What Providers Need to Know

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI**. **For Medicare purposes this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI,** regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians (MD and DO) and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP);
  - Clinical nurse specialists (CNS);
  - Physician assistants (PA); and
  - Certified nurse midwives (CNM).
- Established NPI business requirements for beneficiary submitted (CR 5328), deceased physician (CR 5416), adjustments (CR 5416), beneficiary submitted (CR 4169), flu claims (CR 4169), foreign claims (CR 4169) and pandemic flu claims (CR 4169) remain as written.

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Background

This article is based on Change Request (CR) 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

You may see the official instruction (CR 5674) issued to your Medicare A/B MAC, FI, or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf.

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

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Skilled Nursing Facility (SNF) Consolidated Billing (CB): Additional CWF Editing

What Providers Need To Know

Effective for dates of service on or after April 1, 2001, Change Request (CR) 5757, from which this article is taken, instructs Medicare carriers and A/B MACs to modify the existing therapy edit for Part B claims processing to ensure that all therapy services are subjected to SNF consolidated billing edits when provided in a covered or non-covered SNF stay.

Background

Since therapy services provided in a SNF must be consolidated when a beneficiary is in a SNF stay, whether covered or non-covered by Medicare, Medicare systems will reject claims with dates of service falling within a SNF stay. As a result of this specific change, Medicare's CWF system will reject claims with dates of service after the posted SNF claim until a discharge claim is processed. The entity furnishing the therapy services must look to the SNF for payment, rather than billing Medicare.

Medicare contractors (carrier or A/B MAC) will re-open and re-process inappropriately denied claims for dates of service on or after April 1, 2001, through April 6, 2008, when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. However, if you received payment directly from the SNF, you must return that payment to the SNF before requesting payment through the Medicare contractor.

Additional Information

You may see the official instruction (CR 5757) issued to your Medicare Carrier or A/B MAC by going to http://www.cms.hhs.gov/Transmittals/downloads/R1365CP.pdf. As an attachment to CR 5757, you will find updated *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits).

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

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Crossover of Assignment of Benefits Indicator (CLM08): From Paper Claims

Provider Types Affected

Physicians and suppliers submitting paper claims to Medicare contractors for services provided to Medicare beneficiaries

Provider Action Needed

Impact to You: This article is based on Change Request (CR) 5780 which makes system changes to the manner in which the Medicare sets the CLM08 value in the Coordination of Benefits (COB) flat file for transmission of claims to COB partners.

What You Need to Know: CR 5780 will result in changes to Medicare systems to appropriately set the correct indicator in CLM08 based on the presence of or lack of a patient signature in box/item 13 of the Form CMS-1500.

What You Need to Do: See the Background and Additional Information Sections of this article for further details regarding these changes and be sure billing personnel complete box/item 13 of the Form CMS-1500 in accordance with the revised instructions.

Background

The basic claims form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program is the Form CMS-1500. It answers the needs of many health insurers, and 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 http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html).

Coordination of Benefits (COB) trading partners requested that CMS change the current process of automatically setting a "Y" value in the CLM08 segment of the 837 Professional Coordination of Benefits (COB) claim crossover file. Trading partners may use the CLM08 value to determine where the claim reimbursement is to go and have, in some cases, reimbursed the provider instead of the beneficiary.

Note: CLM08 is the assignment of benefits indicator, and a "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

CR 5780 initiates system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box/item 13 of the Form CMS-1500. In addition, CR5780 revises the Form CMS-1500 claim completion instructions in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits. Specifically, the Medicare Claims Processing Manual (Chapter 26, Section 10.3 – Items 11a-13 – Patient and Insured Information) is

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revised (***changes are bolded and italicized***) as follows:

> ***"Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.***
>
> ***The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.***

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked."

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

The business requirements in CR 5780 do not affect inbound claims or current Medicare claims processing guidelines. They specifically address COB claims only which are sent to trading partners.

Additional Information

The official instruction, CR 5680, issued to Palmetto GBA regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1369CP.pdf.

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

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

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Evaluation & Management Medicare Part B Seminars ~ FREE

Palmetto GBA is presenting **FREE Evaluation & Management Seminars** in Ohio 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
Tuesday, December 4, 2007	**Columbus Metropolitan Library/ South East:** 3980 S. Hamilton Rd. Groveport, OH 43125	10:00 a.m. - 12:30 p.m.
Tuesday, December 4, 2007	**Columbus Metropolitan Library/ Southeast:** 3980 S. Hamilton Rd. Groveport, OH 43125	1:30 p.m. - 4:00 p.m.

Registration:

To register for a seminar go to:

- http://www.PalmettoGBA.com/boh/education (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.

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

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Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

Note: This article was revised on November 7, 2007, to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007". All other information is unchanged.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q HCPCS codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: http://www.gpoaccess.gov/cfr/retrieve.html. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office.** CR 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for HCPCS codes V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for HCPCS codes V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

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Influenza Virus Vaccine and the Pneumococcal Vaccine Payment Allowances: When Payment is Based on 95 Percent of the Average Wholesale Price (AWP)

Provider Action Needed

Be sure your billing staff is aware of the billing rates that are effective for influenza and pneumococcal vaccines provided on or after September 1, 2007. These rates apply, **except where the vaccine is furnished in the hospital outpatient department, in which payment for the vaccine is based on reasonable cost.**

Background

Change Request (CR) 5744, from which this article is taken, provides the payment allowances for: Influenza Virus Vaccines (Current Procedural Terminology (CPT) codes 90655, 90656, 90657, 90658, and 90660), and Pneumococcal Vaccine (CPT 90732 and 90669); when payment is based on 95% of the AWP.

Effective September 1, 2007, the Medicare Part B payment allowance in these situations is as follows:

Influenza vaccine payments are:

- CPT 90655 is $16.109;
- CPT 90656 is $17.366;
- CPT 90657 is $6.609;
- CPT 90658 is $13.218; and
- CPT 90660 (FluMist, a nasal influenza vaccine) is $21.176 and providers should note that CPT 90660 may be covered in those cases where the local Medicare contractor determines that its use is medically reasonable and necessary for the beneficiary.

Pneumococcal vaccine payments are:

- CPT 90732 is $29.730; and
- CPT 90669 is $78.803.

Please note:

- These rates apply, except where the vaccine is furnished in the hospital outpatient department, where payment is based on reasonable cost.
- Annual Part B deductible and coinsurance amounts do not apply.
- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Your Medicare contractors will not search their files to adjust payment for claims paid prior to implementation of these changes; however, they will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR 5744, issued to your Medicare contractor is located at http://www.cms.hhs.gov/Transmittals/downloads/R1357CP.pdf.

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

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Ambulance Transports: Medicare Payments

Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), "Medicare Payments for Ambulance Transports," during the calendar year 2002 twenty-five percent of ambulance transports did not meet Medicare's program requirements. This resulted in an estimated $402 million of improper payments. In two out of three cases, third-party providers (most likely not the patient) who requested transports may not have been aware of Medicare's requirements for ambulance transports.

What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary unless he or she lacks constructive knowledge that the service is not covered. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment.

What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified. It is important to know whether the use of an ambulance transport for your patient would be covered by Medicare, and if so, what level of service would be covered. Please refer to the *Background* section of this Special Edition article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient's health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.

2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient's illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

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Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

a) Basic life support
b) Advanced life support
c) Specialty care transport
d) Air transport – fixed wing and rotary wing

Emergency Ambulance Transport

An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- Place the patient's health in serious jeopardy;
- Result in serious impairment of bodily functions; or
- Result in serious dysfunction of any bodily organ.

Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:

- Severe pain or hemorrhage;
- Unconsciousness or shock;
- Injuries requiring immobilization of the patient;
- Patient needs to be restrained to keep from hurting himself or others;
- Patient requires oxygen or other skilled medical treatment during transportation; and
- Suspicion that the patient is experiencing a stroke or myocardial infarction. See Chapter 15 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 10 of the Medicare Benefit Policy Manual (Pub. 100-2) at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

Non-Emergency Ambulance Transports

Non-emergency ambulance transportation is appropriate with a patient who is bed-confined AND his/her condition is such that other methods of transportation are contraindicated; OR if the patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (patient poses a danger to him or herself or to others). **Bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare benefits**. To be considered bed-confined, **the patient must be unable to do all three of the following**:

- Get up from bed without assistance;
- Ambulate; and
- Sit in a chair or wheelchair.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

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However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to be made available to Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a Physician Certification Statement (PCS) for non-emergency transports. The PCS states the reason(s) a patient requires non-emergency transportation by ambulance. It is effective for 60 days from the date it is signed. The PCS, or proof of the supplier's attempt to obtain it, is required within 48 hours after provision of the ambulance service. The "trip ticket" is documentation used in emergency transports and contains the date, mileage, crew, origin, destination, type and level of ambulance service provided, patient condition, the type of service, and supplies provided to the patient while in transport.

How to Avoid Improper Billing

Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5422 "Ambulance Fee Schedule – Medical Conditions List – Manualization," which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.

Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).

Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

SE 0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, *Medicare Payments for Ambulance Transports*, which is located at http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf.

CR 5422, dated February 23, 2007, "Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions," is located at http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf.

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

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2008 Ambulatory Surgical Center (ASC) Payment System Changes

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is required to implement a new Ambulatory Surgical Center (ASC) payment system no later than January 1, 2008. An overview of the new system has already been provided in the MLN Matters article SE 0742, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf. CR 5680, from which this article is taken, provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system.

Background

Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to implement a new Ambulatory Surgical Center (ASC) payment system not later than January 1, 2008. In part, the law requires that ASCs be paid the lesser of the actual charge or the ASC fee schedule payment rates. See MLN Matters article SE 0742 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf for an overview of the new ASC payment system.

In addition to the new payment instructions, ASCs will be paid a reduced amount for certain procedures when you receive a partial credit for more than 50 percent of the cost of a medical device. You will need to include an FC HCPCS modifier on certain procedure codes that include payment for a device, to report that you received a partial credit for more than 50 percent of the cost of the device. For those procedure codes where the FC HCPCS modifier may be applicable, CMS will provide Medicare contractors with a price for the procedure code, both with and without, the FC HCPCS modifier.

CR 5680 also includes a number of changes to two Medicare manuals as summarized below. (Only the key changes/revisions are included in this article). These revised manual instructions are attached to CR 5680.

Revisions to the Medicare Claims Processing Manual

(These revisions are attached to CR 5680 at http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf.) Key revisions are:

Chapter 1 (General Billing Requirements)
Section 30.3.1 (Mandatory Assignment on Carrier Claims)

For colorectal cancer screening colonoscopies (G0105 and G0121), there is no deductible and a 25 percent coinsurance. Effective January 1, 2008, for service G0104, there will be no deductible and the 25 percent coinsurance rate will apply.

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Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Section 120 (General Rules for Reporting Outpatient Hospital Services)
Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC

Section 180.1 (General Rules)
Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC

Chapter 14 (Ambulatory Surgical Centers)
Section 10 (General)
Beginning January 1, 2008, Medicare will:

- Pay ASCs (under Part B) for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC;
- Pay ASCs (under Part B) for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures;
- Continue to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008; and
- Not pay ASCs for procedures that are excluded from the list of covered surgical procedures or covered ancillary services.

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with the Centers for Medicare & Medicaid Services (CMS). The *State Operations Manual*, which you can find at http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10 describes the certification process.

Section 10.2. (Ambulatory Surgical Center Services on ASC List)
Under the new payment system, ASC services for which payment is included in the ASC payment include, but are not limited to:

- Nursing technician, and related services;
- Use of the facility where the surgical procedures are performed;
- Any laboratory testing performed under a clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate waiver;
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);
- Medical and surgical supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42;

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- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42);
- Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR located at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42;
- Splints and casts and related devices;
- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedures;
- Administrative, recordkeeping and housekeeping items and services;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and
- Supervision of the services of an anesthetist by the operating surgeon.

In addition, Medicare will pay ASCs separately for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. The services are:

- Brachytherapy sources;
- Certain implantable items that have pass-through status under the Outpatient Prospective Payment System (OPPS);
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;
- Certain drugs and biologicals for which separate payment is allowed under the OPPS; and
- Certain radiology services for which separate payment is allowed under the OPPS.

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those that are not usually self-administered, and are considered to be packaged into the payment for the surgical procedure under the outpatient prospective payment system (OPPS). Beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and are separately payable under the OPPS.

Section 10.4. (Coverage of Services in ASCs, Which Are Not ASC Facility Services)
Physician Services

Includes most covered services performed in ASCs, which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs may bill and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASC's and the beneficiaries' recovery from the anesthesia.

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Implantable Durable Medical Equipment (DME)
If the ASC furnishes items of implantable DME items to beneficiaries, the ASC bills and receives payment from the local carrier or A/B MAC for the surgical procedure and the implantable device. When the surgical procedure is not on the ASC list, the physician bills the carrier or A/B MAC for both the surgical procedure and the implanted device, coding the ASC as the place of service (POS code 24) on the bill.

Non-Implantable DME
If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.

Services of Independent Laboratory
As noted in the *Medicare Claims Processing Manual*, Chapter 14, *Section 10.2*., only very limited numbers and types of diagnostic tests are considered ASC facility services and are included in the ASC facility payment rate. Since *Section 1861(s)* of the Act limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics, or hospitals to those that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests that an ASC performs directly are not considered ASC facility services and not covered under Medicare.

The ASC's laboratory must be CLIA certified and will need to enroll with the carrier or A/B MAC, as a laboratory and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC. Otherwise, the ASC must make arrangements with a covered laboratory or laboratories for laboratory services, as set forth in 42CFR416.49 located at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=737c29dc4bb9dd89c5b72ca82f9b40c5&rgn=div8&view=text&node=42:3.0.1.1.3.3.1.10&idno=42

Section 20 (List of Covered Ambulatory Surgical Center Procedures)
The complete lists of ASC covered surgical procedures and ASC covered ancillary services; the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations; and the wage adjusted payment rates, and wage indices are available at http://www.cms.hhs.gov/ASCPAYMENT.

Section 20.1 (Nature and Applicability of ASC List)
The ASC list of covered procedures indicates procedures, which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences. In addition, all the general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services.

Section 20.2. (Types of Services Included on the List)
The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy,

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laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. In addition, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue.

In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures. The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require and overnight stay following the surgical procedure.

Surgical procedures are defined as Category I CPT codes within the surgical range of CPT codes, 10000 through 69999. Also considered to be included within that code range are Level II HCPCS and Category III CPT codes that crosswalk to or are clinically similar to the Category I CPT codes in the range.

The surgical codes that are included on the ASC list of covered surgical procedures are those that have been determined to pose no significant safety risk to Medicare beneficiaries when furnished in ASCs and that are not expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted Category I CPT code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

Section 30 (Rate-Setting Policies)

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for performing the procedure; and,
- The cost of services furnished by the facility where the procedure is performed (e.g., surgical supplies and equipment and nursing services). For a discussion of the ASC payment methodology, see MLN Matters article SE 0742 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf.

Section 40.3. (Payment for Intraocular Lens (IOLs)

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under the *Medicare Claims Processing Manual*, Chapter 14, Section 40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC

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procedure, the contractor will make a separate payment adjustment of $50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard coded system logic that excludes the $150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

Section 40.4 (Payment for Terminated Procedures)

- Facilities use a CPT modifier 73 to indicate that the procedure terminated prior to induction of anesthesia.
- Prior to January 1, 2008, carriers or A/B MACs deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.
- Beginning January 1, 2008, payment for an IOL is included in the payment for the surgical procedure to implant the lens.
- Beginning January 1, 2008, Medicare contractors will apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the CPT modifier 52 to indicate the discontinuance of these applicable procedures.
- Beginning January 1, 2008, ASC surgical services billed with the CPT modifiers 52 or 73 are not subject to the multiple procedure discount.

Section 40.5. (Payment for Multiple Procedures)

- Each surgical procedure has its own CPT-4 code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT-4 code number.
- When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors base the ASC facility payment rate on 100% of the highest paid procedure, plus 50 percent of applicable wage adjusted rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.
- The multiple procedure payment reduction is the last pricing routine applied beginning January 1, 2008 to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with CPT modifiers 73 and 52 will not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with CPT modifier 74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

Section 40.6 (Payment for Extracorporeal Shock Wave Lithotripsy (ESWL))

- Beginning January 1, 2008 with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

Section 40.7 (Offset for Payment for Pass-Through Devices Beginning January 1, 2008)

- Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a

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specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider. Code pairs subject to this policy would be updated quarterly. The CMS will inform Medicare contractors of the code pairs and the percent reduction taken from the procedure payment rate through a "look-up" table.

Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008)

- Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or a full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include an FB HCPCS modifier on the procedure code when a device is furnished without cost or for which full credit is received.
- If the ASC receives a partial credit for the device, the ASC is required to include the FC HCPCS modifier on the procedure code. A single procedure code should not be submitted with both HCPCS modifiers FB and FC. The pricing determination related to the FB and FC modifiers is performed prior to the application of the multiple procedure pricing reductions.

Section 40.9 (Payment for Presbyopia Correcting IOLs (P-C IOLs and Astigmatism Correcting IOLs (A-C IOLs)

- CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively. See http://cms.hhs.gov/center/asc.asp for a current list of CMS recognized P-C IOL and A-C IOL lenses.

Section 50 (ASC Procedures for Completing the Form CMS-1500)

- The Place of Service (POS) code is 24 for procedures performed in an ASC.
- Prior to January 1, 2008, Type of Service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS 2 (surgery) for professional services rendered in an ASC is appropriate.
- Beginning January 1, 2008, ASCs are no longer required to include the SG HCPCS modifier on facility claims in Medicare. HCPCS modifier – TC is required unless the code definition is for the technical component only.

Section 60 (Medicare Summary Notices (MSN), Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs)
Section 60.1 (Applicable messages for NTIOLs)

Carriers or A/B MACs will return, as unprocessable, any claims for NTIOLs containing HCPCS code Q1003 alone or with a code other than one of the procedure codes listed in Section 40.5.2, Chapter 14, of the *Medicare Claims Processing Manual.* They will use the following messages for these returned claims:

- Claim Adjustment Reason Code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;

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- RA Remark Code M67 - Missing/Incomplete/Invalid other procedure codes; and
- RA Remark Code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/ correct information.

Carriers or A/B MACs will deny payment for HCPCS code Q1003 if services are furnished in a facility other than a Medicare-approved ASC and use the following messages when denying these claims:
- MSN 16.2 - This service cannot be paid when provided in this location/facility; and
- Claims Adjustment Reason Code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers or A/B MAC will deny payment for HCPCS code Q1003 if billed by an entity other than a Medicare-approved ASC and use the following messages when denying these claims:
- MSN 33.1 - The ambulatory surgical center must bill for this service; and
- Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.

Carriers or A/B MACs shall deny payment for HCPCS code Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011) and use the following messages when denying these claims:
- MSN 21.11 - This service was not covered by Medicare at the time you received it; and
- Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.

Section 60.2 (Applicable messages for ASC 2008 payment changes effective January 1, 2008)
Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) for POS 24 using the following messages:
- Claim Adjustment Reason Code 8 - The procedure code is inconsistent with the provider type/ specialty;
- RA Remark Code N95 - This provider type/provider specialty may not bill this service; and
- MSN 26.4 – This service is not covered when performed by this provider.

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors will return pass-through device claims/line items, brachytherapy claims/line items, drug code (including C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASC DRUG list as unprocessable using the following messages:
- Claim Adjustment Reason Code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA Remark Code MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and.
- RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

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Contractors shall deny all ancillary services (e.g., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using the following messages:

- MSN 16.2 – This service cannot be paid when provided in this location/facility;
- Claim Adjustment Reason Code 171 - Payment is denied when performed/billed by this type of provider in this type of facility;
- RA Remark Code M97 - Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility; and
- RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny separately billed implantable devices using the following messages:

- MSN 16.32 - Medicare does not pay separately for this service;
- RA Remark Code M97 – Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility;
- RA Remark Codes M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed;
- MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and
- M16 - Please see our web site, mailings or bulletins for more details concerning this policy/procedure/decision (contractor discretion).

If there is a related, approved surgical procedure for the billing ASC for the same date of service, they will also include the following message:

- MSN 16.8 - Payment is included in another service received on the same day.

Chapter 19 (Indian Health Services)
Section 40.2.1 (Provider Enrollment with FI or AB MAC - Ambulatory Surgical Services)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ambulatory surgical center (ASC) list and receive the ASC rate must contact their designated FI or AB MAC. IHS providers are certified by one of several national accrediting organizations recognized by the Centers for Medicare & Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42CFR482 located at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into Public Health Service (PHS) regulations on December 27, 1989. The first IHS hospital requested and received approval from CMS to bill separately for ASC procedures at the appropriate ASC group payment amount for dates of service on or after October 1, 1987. Previously, the hospital was

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reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all-inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified; encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

Effective for dates of service on or after January 1, 2008, the FI or A/B MAC no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier or A/B MAC.

Chapter 26 (Completing and Processing Form CMS-1500 Data Set)
Section 10.7 (Type of Service (TOS))
Effective for services on or after January 1, 2008, the SG HCPCS modifier is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the SG HCPCS modifier on Medicare ASC facility claims.

Revisions to the Medicare Benefit Policy Manual

Changes to this manual are basically the same, as appropriate, as those made to the *Medicare Claims Processing Manual*. The revised portions of the *Medicare Benefits Policy Manua*l are also attached to CR 5680 at http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf.

Additional Information

The two transmittals related to CR 5680 are at
http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf and
http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf. Attached to these transmittals are the revised manual chapters discussed in this article. These transmittals are the official instructions issued to your Medicare contractor.

Also, the MLN Matters article providing an overview of the new ASC payment system is at
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf.

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

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Unlabeled Use for Anti-Cancer Drugs: Medical Literature used to Determine Medically Accepted Indications for Drugs and Biologicals for Anti-Cancer Treatment

Note: This article was revised on October 16, 2007, to reflect that the Centers for Medicare & Medicaid Services decision memorandum on this issue has now been posted at http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=9. All other information remains the same.

Provider Action Needed

This article is informational only and it is based on Change Request (CR) 5729, which revises the *Medicare Benefit Policy Manual,* (Chapter 15, Section 50.4.5 (Unlabeled Use for Anti-Cancer Drugs)).CR 5729 adds 11 peer-reviewed medical journals to the existing list of 15 peer-reviewed medical journals used to determine medically accepted indications for drugs and biologicals used in Anti-Cancer Treatment. Medicare contractors processing Medicare claims use this list of medical journals to determine whether there is supportive clinical evidence for a particular use of a drug in the treatment of Medicare beneficiaries. None of the 15 existing peer-reviewed medical journals are being deleted at this time.

Background

The Social Security Act (Section 1861(t)(2)(B)(ii)(II); http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) states that

> "the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary."

Accordingly, Section 50.4.5 of the Medicare Benefit Policy Manual (Chapter 15, Section 50.4.5; (http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf) lists 15 peer-reviewed journals that a Medicare contractor must use to determine "whether there is supportive clinical evidence for a particular use of a drug."

These 15 peer-reviewed medical journals include:

- American Journal of Medicine;
- Annals of Internal Medicine;
- The Journal of the American Medical Association;
- Journal of Clinical Oncology;
- Blood;
- Journal of the National Cancer Institute;
- The New England Journal of Medicine;
- British Journal of Cancer;

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- British Journal of Hematology;
- British Medical Journal;
- Cancer;
- Drugs;
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);
- Lancet; and
- Leukemia.

In letters dated May 21, 2003 (2003 letter) and May 4, 2006 (2006 letter) the American Society of Clinical Oncology (ASCO) noted that this list of 15 journals was created in 1993, and it has not been revised since that time. ASCO formally submitted requests for the Centers for Medicare & Medicaid Services (CMS) to revise the list of 15 journals by adding 14 more journals.

CMS staff conducted a review of the journals listed in the ASCO requests. In addition, CMS informally consulted oncology experts from the National Cancer Institute (NCI) at the National Institutes of Health (NIH) and from the Center for Drug Evaluation and Research at the Food and Drug Administration (FDA) to request their opinions about the ASCO-recommended journals. CMS also provided public notice and solicited public comment through a CMS Web site posting from October 27, 2006, through December 26, 2006 (http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=9). The CMS decision memorandum on this issue has also been posted at this Web site. CMS staff integrated the data from its review and from the above sources into its final decision to add the following 11 journals to the current list of 15 journals at section 50.4.5 of the *Medicare Benefit Policy Manual*:

- Annals of Oncology;
- Biology of Blood and Marrow Transplantation;
- Bone Marrow Transplantation;
- Gynecologic Oncology;
- Clinical Cancer Research;
- International Journal of Radiation, Oncology, Biology, and Physics;
- Journal of the National Comprehensive Cancer Network (NCCN);
- Radiation Oncology;
- Annals of Surgical Oncology;
- Journal of Urology; and
- Lancet Oncology.

Medicare carriers are not required to maintain copies of these publications. If a claim raises a question about the use of a drug for a purpose not included in the FDA-approved labeling or the compendia, the carrier will ask the physician to submit copies of relevant supporting literature.

Additional Information

The official instruction, CR 5729, issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R78BP.pdf.

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

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2007-2008 Influenza (Flu) Season Resources

Provider Action Needed

- Keep this Special Edition *MLN Matters* article and refer to it throughout the 2007 - 2008 flu season.
- Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without any out-of-pocket costs to the Medicare beneficiaries, (i.e., no deductible or copayment/coinsurance.)
  - Stay abreast of the latest flu information and inform your patients.
  - Order appropriate provider resources for yourself and your staff.
- Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – **Get the Flu Shot – Not the Flu!**

Introduction

Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health!

- While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
- Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
- Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. **Get Your Flu Shot – Not the Flu!**

Helping You Stay Informed

CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

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Continued from previous page

Products

1. MLN Matters Articles

- **MM5744:** Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf.
- **MM5511:** Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 For Part B Influenza Billing located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf.
- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf.
- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf.

2. MLN Influenza Related Products for Health Care Professionals

- ***Quick Reference Information: Medicare Immunization Billing* -** This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf.

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition** - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file. Updated August 2007 at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.

- ***Medicare Preventive Services Adult Immunizations Brochure*** - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Updated August 2007. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf.

- ***Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course*** - This WBT course contains four modules that include information about Medicare's coverage of influenza,

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pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the MLN Product Ordering Web page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program** - This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering Web page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

- ***Quick Reference Information: Medicare Preventive Services -*** This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.

- ***Medicare Preventive Services Bookmark -*** This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

MLN Preventive Services Educational Products Web Page - This Medicare Learning Network (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) for easy access.

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** located at http://www.cms.hhs.gov/AdultImmunizations/.
- **CMS Frequently Asked Questions** located at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi.

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- **Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations** located at http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf.
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** located at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007 – 2008 flu season:

- **Advisory Committee on Immunization Practices** located at http://www.cdc.gov/vaccines/recs/acip/default.htm.
- **American Lung Association's Influenza (Flu) Center** located at http://www.lungusa.org**.** - This site provides a flu clinic locator at http://www.flucliniclocator.org. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- **Centers for Disease Control and Prevention -** http://www.cdc.gov/flu
- **Immunization Action Coalition -** http://www.immunize.org
- **Immunization: Promoting Prevention for a Healthier Life -** http://www.nfid.org/pdf/publications/naiaw06.pdf
- **Medicare Quality Improvement Community -** http://www.medqic.org
- **National Alliance for Hispanic Health -** http://www.hispanichealth.org/
- **The National Center for Immunization and Respiratory Diseases (NCIRD) (**established spring 2007) replaces the name National Immunization Program (NIP) - http://www.cdc.gov/vaccines/about/
- **National Foundation For Infectious Diseases -** http://www.nfid.org/influenza
- **National Network for Immunization Information -** http:/www.immunizationinfo.org
- **National Vaccine Program -** http://www.hhs.gov/nvpo
- **Office of Disease Prevention and Promotion -** http://odphp.osophs.dhhs.gov
- **Partnership for Prevention -** http://www.prevent.org
- **World Health Organization -** http://www.who.int/csr/disease/influenza/en/

Additional Information

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

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Low Vision Rehabilitation Demonstration: Revisions to Change Request 4294

What You Need to Know

CR 5756, from which this article is taken, revises some of the Medicare Low Vision Rehabilitation Demonstration coverage limitations described in CR 4294 (released January 20, 2006). Specifically, it changes the limitation of services from 9 hours of rehabilitation services in one consecutive 90-day period (once in a lifetime) to 12 hours of rehabilitation services ***per calendar year.*** You should make sure that your billing staffs are aware of these Medicare Low Vision Rehabilitation Demonstration coverage changes, which are effective for services supplied under the demonstration on or after April 1, 2008.

Background

To improve participation among eye care physicians in the Low Vision Rehabilitation Demonstration and to correct unnecessary limitations in level of low vision rehabilitation coverage, CR 5756, from which this article is taken, revises CR 4294 (Revisions to CR 3816 - Low Vision Rehabilitation Demonstration), released January 20, 2006. Specifically, it changes the 90-day, once in a lifetime limitation for vision rehabilitation services to *a calendar year basis*; and increases the number of hours of covered vision rehabilitation services to which a participating beneficiary is entitled from 36 units of 15-minutes each (9 hours), to 48 units of 15 minutes each (12 hours).

Additional Information

You can find the official instruction conveying the revisions to the Medicare Low Vision Rehabilitation Demonstration coverage limitations by going to CR 5756, located at http://www.cms.hhs.gov/Transmittals/downloads/R54DEMO.pdf.

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

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Bone Mass Measurements (BMMs)

THE IMPORTANCE OF:
Additional Documentation & Correct Use of Modifiers

How much time and money does your practice spend researching denials, gathering documentation, and appealing denied claims? In many cases, these claims could have been reimbursed the first time they were submitted if all of the correct and required information had been submitted. To minimize claim denials based on these reasons, it is important to verify Medicare coverage and reimbursement guidelines before submitting the claim.

Denied Claims & Appeals of Denied Claims Overview

Medicare claims may be denied for a number of reasons. The four most common reasons that claims are denied (excluding "billing errors") are:

- Medical necessity
- The service has already been paid (duplicate)
- The service was included in the global surgery payment and cannot be separately reimbursed
- Reimbursement for the service was bundled into another procedure (Correct Coding Initiative)

We have analyzed claims that are denied initially and then later paid on appeal. One of the most common services that were not paid initially is Bone Mass Measurments.

Solution:

- CMS issued instructions to clarify that only dual energy x-ray absorptiometry (CPT code 77080) is allowed to monitor osteoporosis drug therapy. ***Initial claims*** for CPT 77080 must be submitted with:

    - The type of osteoporosis drug therapy that patient is receiving that requires bone density studies more frequently than every two years must be submitted with the initial claim
    - The date that treatment with the drug was initiated
    - If the patient is not receiving drug therapy for osteoporosis, include in the documentation the name and daily dose of drug therapy that may adversely affect bone density

- Palmetto GBA will not reimburse other CPT codes (77078, 77079, 77081 etc.) for bone density studies when the reason for the study is monitoring osteoporosis drug therapy.

- Submit this additional documentation in the documentation record for electronic claims. If you meet the criteria to submit paper claims, submit this additional documentation as an attachment to the claim.

Resources:

- Palmetto GBA *Medicare Advisory*, July 2007:
  http://www.PalmettoGBA.com/boh/advisory http://www.PalmettoGBA.com/bwv/advisory

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- Palmetto GBA Local Coverage Determination, "Bone Mass Measurement" and related article "Bone Mass Measurement Coding Guidelines":
  - Ohio: http://www.PalmettoGBA.com/boh/LCD
  - West Virginia: http://www.PalmettoGBA.com/bwv/LCD
- CMS *MLN Matters* article MM5521: http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5521.pdf
- National Coverage Determination, "Bone (Mineral) Density Studies": search the CMS Medicare Coverage Database at http://www.cms.hhs.gov/mcd/overview.asp

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Paravertebral Facet Joint Block

THE IMPORTANCE OF:
Additional Documentation & Correct Use of Modifiers

How much time and money does your practice spend researching denials, gathering documentation, and appealing denied claims? In many cases, these claims could have been reimbursed the first time they were submitted if all of the correct and required information had been submitted. To minimize claim denials based on these reasons, it is important to verify Medicare coverage and reimbursement guidelines before submitting the claim.

Denied Claims & Appeals of Denied Claims Overview

Medicare claims may be denied for a number of reasons. The four most common reasons that claims are denied (excluding "billing errors") are:

- Medical necessity
- The service has already been paid (duplicate)
- The service was included in the global surgery payment and cannot be separately reimbursed
- Reimbursement for the service was bundled into another procedure (Correct Coding Initiative)

We have analyzed claims that are denied initially and then later paid on appeal. One of the most common services that were not paid initially is Paravertebral Facet Joint Block.

Solution:

- Coverage for Paravertebral facet joint blocks is based on Palmetto GBA's Local Coverage Determination (LCD).

- Palmetto GBA may reimburse up to 3 unilateral or 3 bilateral facet blocks on a single date of service.

- **Bilateral blocks**: CPT modifier 50 (bilateral procedure) MUST be included with the appropriate CPT code(s) for any level to denote that bilateral blocks were performed at that level.

- Reimbursement for services that are submitted without CPT modifier 50 will be based on **unilateral** blocks.

Resources:

- Palmetto GBA *Medicare Advisory*, September 2007: http://www.PalmettoGBA.com/boh/advisory http://www.PalmettoGBA.com/bwv/advisory
- Palmetto GBA Local Coverage Determination, "Paravertebral Facet Joint Blocks" and related article "Paravertebral Facet Joint Block Coding Guidelines":
  - Ohio: http://www.PalmettoGBA.com/boh/LCD
  - West Virginia: http://www.PalmettoGBA.com/bwv/LCD

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Multiple Surgeries, Same Day

Avoid delays and denials by submitting procedures subject to multiple surgery payment rules on the SAME claim whenever possible.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed.

Steps to follow:

- Determine whether the procedure is subject to multiple surgery rules by accessing the CMS Medicare Physician Fee Schedule Database: http://www.cms.hhs.gov/PFSlookup.
- If the **multsurg** field for the surgical procedure indicates "2," multiple surgery payment rules apply when performed on the same day as another procedure subject to multiple surgery payment rules.
    - The procedure with the highest fee schedule is paid at 100%.
    - Other procedures with indicator 2 are reduced by 50%.
- If the **multsurg** field for the surgical procedure indicates "3," special rules for multiple endoscopic procedures apply. These services should also be submitted on the same claim.
- If the second surgery on the same date is performed at a different time (e.g., due to complications that required a return trip to the operating room, or an unrelated surgical procedure), a modifier may be required. Refer to instructions in the Palmetto GBA **Modifier Lookup tool** for instructions on submitting and documenting CPT modifiers 78 and 79.
- Some electronic billing software is set up to allow a limited number of detail lines to be transmitted per claim. Palmetto GBA, in accordance with the ANSI 837 X12 Implementation Guide can accpet up to 50 detail lines per claim. You may want to consider talking to your software vendor to increase the available number of lines per claim.

The reductions are applied regardless of whether the services are submitted on the same or separate claims. However, when services are submitted on separate claims, additional processing time is required and may delay payment or result in denial of the service(s).

Resources:

- Additional information regarding reimbursement calculations for multiple surgeries is available in the CMS *Medicare Claims Processing Manual* (Pub. 100-04), chapter 12, Section 40.6: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf.
- The Palmetto GBA Modifier Lookup tool provides guidance on submitting and documenting CPT modifiers 78 and 79. Access the tool directly from the Ohio and West Virginia home pages:
    - Ohio: http://www.PalmettoGBA.com/boh
    - West Virginia: http://www.PalmettoGBA.com/bwv
- For more information about how Medicare reimburses surgical procedures, refer to the *Physician/ Supplier Guide* chapter on the Global Surgery Package:
    - Ohio: http://www.PalmettoGBA.com/boh/guide
    - West Virginia: http://www.PalmettoGBA.com/bwv/guide

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Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscsopy

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services to clarify billing instructions for the Medicare beneficiary who

1) presents for a screening colonoscopy (or flexible sigmoidoscopy),
2) has no gastrointestinal symptoms, and
3) during their screening colonoscopy (or flexible sigmoidoscopy), have an abnormality identified (such as a polyp, etc.) which is biopsied or removed.

Change Request Number: N/A

Background

CMS has become aware of confusion regarding billing for colorectal screening arising because of wording in the Medicare Physician Fee Schedule (MPFS) Final Rule for 2007 (Federal Register, Vol. 71, No. 231, page 69665, December 1, 2006 (See the MPFS Final Rule at http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1321fc.pdf.

The relevant section of the 2007 MPFS states, regarding screening colonoscopies, that:

> "If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal." Based on this statutory language, in such instances the test or procedure is no longer classified as a "screening test." Thus, the deductible would not be waived in such situations.

The above scenario can be restated as follows:

- A patient presents for a screening colonoscopy (or flexible sigmoidoscopy), and the patient has no gastrointestinal symptoms.
- During the subsequent screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed.

CMS advises that, whether or not an abnormality is found, if a service to a Medicare beneficiary starts out as a screening examination (colonoscopy or sigmoidoscopy), then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9 code for the screening examination.

As an example, the above scenario should be billed as follows using claim form CMS-1500 (or its electronic equivalent):

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Additional Information

For related MLN Matters articles on colorectal cancer screenings, see articles SE 0710 and MM 5387, which are available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf.

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

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Lumbar Artificial Disc Replacement (LADR)

The August 14, 2007, CMS Decision Memo reported insufficient scientific evidence to support LADR as a reasonable and necessary service for Medicare beneficiaries > 60 years of age.

Due to the limited size and scope of current studies and to maintain consistency within the Medicare population, Palmetto GBA has determined the current scientific evidence does NOT support the use of LADR in beneficiaries < 60 years of age.

Therefore, until more conclusive results document the safety and efficacy of this service, Palmetto GBA will NOT reimburse LADR services.

Reference: Lumbar Artificial Disc Replacement (LADR) (150.10)

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

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

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

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

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

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

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Continued from previous page

Local Coverage Determination Updates

LCD	Change	Effective Date
Bone Mass Measurement 2001-37LR18	Clarification under Non Covered ICD-9 section of the policy.	01/01/2007
Chemodenervation 2001-25LR11	Addition of ICD-9 codes 478.31, 478.33, 478.75 and 784.49 to support medical necessity of CPT code 64613 due to descriptor change of CPT code 64613 effective 01/01/2006. Deletion of unlisted CPT code 31599 from policy.	01/01/2006
Chemotherapy and Biologicals 2002-29LR35 Chemotherapy and Biologicals 2002-29LR36	Addition of HCPCS code J9999 for Ixabepilone (Ixempra) for ICD-9 codes 174.0-175.9 Addition of ICD-9 codes 200.40-200.48 as supporting medical necessity for HCPCS code J9041 (Velcade).	11/01/2007 11/15/2007
Obesity/Bariatric Surgery 2002-40LR6	Retired LCD National Coverage (NCD # 40.5, 100.1, & 100.8) is continued.	10/17/2007
Stretta Procedure 2004-07L	Retired	11/07/2007
Draft LCDs	**Change**	**Effective Date**
Cardiac Computed Tomography & Angiography (CCTA) 2006-01LR2	Criteria and verbiage changes made to the Indications and Limitations section of the policy. Expanded and clarified specifications. Additional references added to Sources of Infomation section. Policy will be taken to the December Carrier Advisory Committee Meetings for Ohio and West Virginia.	04/01/2008
Sedation and Analgesia by Non-anesthesiologists 2007-02L	New draft policy to be shared in December Carrier Advisory Committee Meetings for Ohio and West Virginia.	To be determined

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