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Medicare advisory

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2007, Issue 1 *www.cms.hhs.gov* *www.PalmettoGBA.com* *January 2007*

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You Are Responsible. . .

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

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

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Palmetto Place

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

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

The List Serv Fairy to the rescue....

Want to stay informed? Just register to receive email notifications. It's EASY and it's FREE!

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

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

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Medicare Education: Small Providers

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

Benefits of Attending

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

You Are Invited!

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

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

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How to Register

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

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

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

No Internet access?

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

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

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

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

Continued on next page

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Registration Form: Palmetto GBA Small Provider Forums

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

Name: _____

Practice Name: _____

Practice Address: _____

_____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

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

Name and number of persons attending: _____

To Be Completed by Palmetto GBA

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

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

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

Palmetto GBA is accepting Medicare Part B Individual Small Provider Appointments!

Date: Wednesday, January 24, 2007

This is an excellent opportunity for you to meet with a Community Education Administrator… one-on-one! Obtain individualized education to address the Medicare concerns that your office may have. Please note: if you are requesting an individual appointment, you must submit your request for an appointment by January 17, 2007. Fax all topics and questions to be discussed during the appointment to 614-473-6812.

A Palmetto GBA representative will contact you by January 19, 2007, to confirm the time and location of your appointment or to make alternate arrangements.

How to Register - One-on-One Small Provider Appointment

Complete the attached Meeting Fax form and fax the form to 614-473-6812

Reminder: Palmetto GBA will also be conducting the following workshop:
Date: Wednesday, January 24, 2007

Location:
Toledo - Lucas County Public Library Heatherdowns
3265 Glanzman
Toledo, OH 43614

Topics and Time: Small Provider Forum (1:00 PM – 4:00 PM)

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

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

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

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

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

Please review your schedule and sign up today!

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

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

Meeting Date and Time of Day Requested:

Date	Start Time	End Time
_____	_____	_____

Optional Dates and Times:

Date	Start Time	End Time
_____	_____	_____
_____	_____	_____

Group/Individual Sponsoring Event _____

Contact Person _____ Contact Phone _____ Fax _____

E-mail _____ Registration Web Address _____

Meeting Facility _____

Meeting Facility Address _____

City _____ State _____ Zip Code _____

Facility Phone _____

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

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

_____

_____

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

_____

_____

Requested Agenda Topics

_____

_____

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

Meeting Open _____ Closed _____

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Free Chiropractic Services Medicare Part B Seminar

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

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

Ohio Seminars

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

Registration:

To Register for a seminar go to:

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

You will need to login with your username and password to register. In order to register for a seminar, you must first create a username and password. Please call 1-877-567-9232 and select the option for education if you have additional questions.

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Free Evaluation & Management Medicare Part B Seminars

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

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

Ohio Seminars

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

West Virginia Seminars

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

Registration:

To Register for a seminar go to:

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

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

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

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Claims Submitted With Only a National Provider Identifier (NPI) During the Stage 2 NPI Transition Period

Provider Types Affected

Physicians who conduct HIPAA standard transactions with Medicare such as claims and eligibility inquiries.

Provider Action Needed

STOP – Impact to You

Beginning October 1, 2006, and until further notice, claims that you submit containing only an NPI will be returned to you as unprocessable if a properly matching legacy number cannot be found.

CAUTION – What You Need to Know

From the beginning of Medicare's Stage 2 NPI transition period on October 1, 2006, and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly processed. During this period, claims submitted with only a NPI, that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), **will** be rejected and you will be required to resubmit the claim with the appropriate legacy number.

What You Need to Do

You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submits both your NPI and legacy provider numbers until further notice from CMS.

Background

As previously announced, the Centers for Medicare & Medicaid Services (CMS) plans to begin testing new software it has been developed to use the NPI in the existing Medicare fee-for-service claims processing systems. (Remember that you will be required to submit claims and other HIPAA transactions with only an NPI beginning on May 23, 2007).

During the Stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare will accept claims having only NPIs (as well as those having only legacy provider numbers); however in CR 5378, from which this article is taken, CMS recommends that during this period you submit claims using:

- The provider's legacy number, such as a Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Both the provider's NPI and legacy number.

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Note: Until January 2, 2007, NPIs are not to be submitted on paper claims via CMS 1500 forms. Institutional providers are advised that the NPI will not be accepted on paper claims by FIs or A/B MACs until implementation of the UB-04 on May 23, 2007.

Until testing of Medicare's new software is complete, if you submit Medicare claims with only your NPI:

1) Will be rejected, or
2) If the Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number), will be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

Additional Information

The official instruction issued to your Medicare contractor on this issue, CR 5378, is available at http://www.cms.hhs.gov/Transmittals/downloads/R249OTN.pdf on the CMS Web site.

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

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Correct Coding Initiative (CCI) Edits, Version 13.0: Effective January 1, 2007

Background

This article and related Change Request (CR) 5422 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The latest package of Correct Coding Initiative (CCI) edits, Version 13.0, effective January 1, 2007, will be available via the CMS Data Center (CDC).

Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at http://www.cms.hhs.gov/NationalCorrectCodInitEd/ on the Centers for Medicare & Medicaid Services (CMS) Web site.

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, Version 13.0, is effective on January 1, 2007. This version will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table; and
- MEC Edits table.

Additional Information

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS Web site.

You may see the official instruction (CR 5422) issued to your Medicare carrier or A/B MAC by going to the CMS Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1124CP.pdf.

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

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Medically Unlikely Edits (MUEs)

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, HCPCS code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- CR 5402 states that Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that will be implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.
- An appeals process will not be allowed or required for claims that are RTP'ed (rejected) as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- Excess **charges due to units of service greater than the MUE** may not be billed to the beneficiary (this **is a "provider liability"**), and this provision can neither be waived nor subject to an Advance Beneficiary Notice (ABN).

Additional Information

Complete details regarding CR 5402 are located at http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf on the CMS Web site.

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

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Drug/Radiopharmaceutical Not Otherwise Classified Codes National Drug Code Number: Required January 1, 2007

Effective January 1, 2007, when a "not otherwise classified" or "unlisted" HCPCS procedure code is submitted [J3490, J3590, J7599, J7699, J9999, A4641, A9699, and/or A9700], the National Drug Code (NDC) number must be in block 19 or on an attachment to the CMS-1500 claim form. For electronic claims, this information must be included in the electronic documentation record, which is 2410 Loop/LIN Segment.

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

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

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Medicare Part B Drug Competitive Acquisition Program (CAP): Do Not Bill a Prescription Order Number More Than Once

Provider Types Affected

Physicians participating in the CAP for Part B Drugs and Biologicals

Provider Action Needed

Impact to You

A CAP prescription order number must **only be used on one claim line.** It should not be reused on another claim line on the same claim, and it should not be reused on any other claim.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has found some CAP claims are being processed incorrectly when CAP prescription order numbers are reused when billing for CAP drugs.

What You Need to Do

The prescription order number is intended to be a unique identifier, and it should not be reused.

Background

This special edition article is being released by the CMS to provide a clarification on billing for drugs under the CAP for Part B Drugs and Biologicals.

CAP Claims Processing

In order for the CAP vendor's drug claim to be processed and paid, physicians must submit:

- A corresponding drug administration claim; and
- A no-pay claim line for the drug.

The vendor's drug claim and the physician's claim are then matched in the claims processing system by the prescription order number, and the vendor is paid for the drug that was administered.

A physician's no-pay claim line consists of:

- The CAP drug's Health Care Procedure Coding System (HCPCS) code,
- A billed amount (which must not equal zero), and
- The number of HCPCS billing units that were administered.

The CAP prescription order number is:

- A **unique** number generated by the approved CAP vendor;
- Used to match CAP claims in the payment system; and
- Associated with a line on an electronic claim.

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CMS has found that some CAP claims are being processed incorrectly due the following:

- Drugs ordered under one, unique prescription order number are being billed on multiple claim lines; and
- The prescription order number **is being reused** with the CPT modifier 76. (See the Additional Information Section of this article for a definition of CPT modifier 76.)

Note: A CAP prescription order number must **only be used on ONE claim line.** It should not be reused on another claim line on the same claim, and it should not be reused on any other claim.

CAP Billing Example

If a CAP vendor has shipped a drug using one prescription order number but the drug is administered in several doses, the total amount administered should be identified in the number of billing units.

Example:

The approved CAP vendor has shipped 20 Heparin Units of HCPCS code J1642 Heparin Sodium (Heparin Lock Flush) under the prescription order number QXXXJ1642YYYYY. (**Note**: HCPCS Code J1642 has the descriptor: Inj heparin sodium per 10 u.)

- The patient's IV lines required **two 10 Unit heparin flushes** during the course of the office visit.
- Since the HCPCS code defines J1642 as 10 Units of heparin and a total of 20 units of heparin were administered, this situation would be:
  - Billed as **2 billing units of HCPCS code J1642** on a line containing a HCPCS modifier of J1 no-pay CAP modifier, and
  - Associated with prescription order number QXXXJ1642YYYYY.

Additional Information

If you have any questions, please contact your carrier at their toll-free number, which may be found at on CMS' Web site at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip

For additional information about CAP billing refer to the billing tip sheet on CMS Web site at www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap_billtips.pdf.

Physician billing information on the Competitive Acquisition Program (CAP) may be found on CMS' Web site at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp.

In addition, you can find MM 4064 (MMA- Competitive Acquisition Program (CAP) for Part B Drugs – Coding, Testing, and Implementation) at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4064.pdf on the CMS Web site.

You can also find SE 0672 (Clarification of Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals) on CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0672.pdf.

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CPT Modifier 76- Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the CPT modifier **76** to the repeated service.

Note: When it is medically necessary to repeat a service, the first service should be reported in the usual manner. The repeat service should be reported on the next line with CPT modifier 76 appended to the procedure code. In the event it is medically necessary to repeat a procedure more than twice, report the second line with the CPT modifier 76 and the appropriate number of units in the unit's field. If a service is repeated more than once, additional documentation should be provided in the narrative field of the claim to support the medical necessity of the repeat services. The patient's medical records must always document the medical necessity of performing repeat procedures and be available to the carrier upon request.

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Competitive Acquisition Program (CAP): Claim Processing for NOC Drugs

Impact on Providers

This article is based on Change Request (CR) 5259, which describes the process for adding Not Otherwise Classified (NOC) Drugs to the CAP beginning in 2007. It provides additional details, information and instructions for the implementation of the CAP as outlined previously in CRs 4064, 4306, 4309 and 5079 and the *MLN Matters* articles related to those CRs.

Background

As discussed in the November 21, 2005, CAP final rule (http://www.access.gpo.gov/su_docs/fedreg/a051121c.html) and in response to public comments about beneficiary access to new medications, CMS provided for the addition of NOC drugs to the CAP beginning in 2007. CMS believes that the addition of NOC drugs to the CAP will improve beneficiaries' access to newly marketed drugs that have a national sales price, will decrease the reliance on buy and bill acquisition and will further simplify the drug acquisition process for physicians who have elected to participate in the CAP.

PROCESS TO ADD NOC DRUGS TO A CAP VENDOR'S DRUG LIST

The process for adding NOC drugs to the CAP will basically follow the process for adding other drugs to the CAP as described in CR 5079. An approved CAP vendor will be required to submit a written request to add specific NOC drugs to the CAP designated carrier. The request must include:

- A rationale for the proposed change,
- A discussion of the impact on the CAP (including safety, waste, etc.), and
- The potential for cost savings.

CMS will define a list of CAP NOC drugs that the approved CAP vendor must use when requesting the addition of NOC drugs to the CAP. The CAP NOC drug list will be based on the ASP NOC list, but will include only drugs that are both likely to fit the existing CAP drug category (or categories) and drugs that have a single national ASP-based payment amount. The CAP NOC drug list will be posted on the CMS CAP Web site and updated quarterly.

If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS website (http://www.cms.hhs.gov/CompetitiveAcquisforBios/) and notify the carriers and participating CAP physicians of any changes on a quarterly basis. Participating CAP physicians will be notified of changes to their approved CAP vendor's CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. CAP drug list approvals apply only to the CAP vendor who submitted the request and to the category identified on the request. Therefore, each vendor's drug list may contain different drugs after changes to the initial drug list are approved. The CAP NOC drug payment amount will be at the same rate as published on the ASP NOC file consistent with the next quarterly update, and the payment amount will be updated annually as for other CAP drugs.

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CAP NOC CLAIMS SUBMISSION REQUIREMENTS

CMS requires the use of a CAP-specific HCPCS Q code (Q4082 Drug/bio NOC part B drug CAP) for CAP NOC drug claims in order to distinguish CAP NOC drug claims from ASP NOC claims and to prevent the CAP claims from being paid outside the Medicare Part B drug CAP.

Physician drug administration claims for CAP NOC drugs are required to use the CAP-specific NOC Q-code: HCPCS code Q4082 Drug/bio NOC part B drug CAP and identify the specific NOC drug that had been administered in Item 19 on paper claims or Loop 2300 Segment NTE on electronic claims.

Physician claims must also contain the appropriate CAP HCPCS modifiers (J1, J2, J3) All other CAP claim parameters will remain the same.

Note: Physicians who have elected to participate in the CAP should continue to use ASP NOC codes when billing for NOC drugs that are outside the CAP. Also remember that physicians who participate in the CAP are required to obtain all CAP drugs on the updates from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor.

RETURNED CAP NOC CLAIMS

For the following three situations, if:

- The claim is submitted with a CAP NOC code, but the description does not match a CAP NOC drug on the approved list; or
- The claim is submitted with a CAP NOC code by a non-CAP physician; or
- The claim is submitted with a J NOC code with a description of a CAP approved NOC drug.

Then:

Claims will be returned to physicians with a reason code of 16 (Claim/service lacks information needed for adjudication) and remark code MA 130 (Your claims contain incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable).

Remark code N350 (Missing/incomplete/invalid description of a service for a NOC code or unlisted procedure) will also appear in the first situation.

Remark code N56 (Procedure code billed is not correct/valid for the services billed or the date of service billed) will appear in the second and third situations.

Implementation

The implementation date for CR 5259 is January 2, 2007.

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Additional Information

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

Change Request (CR) 5259 is not a stand-alone CR. It provides additional details, information, and instructions for the implementation of the Competitive Acquisition Program (CAP) as outlined in:

- CR 4064 (http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf**;** http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf),
- CR4306 (http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf),
- CR4309 (http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf ; http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf) and
- CR 5079 (http://www.cms.hhs.gov/Transmittals/downloads/R1055CP.pdf; http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf).

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed on CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1034CP.pdf.

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

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

Provider Action Needed

This article is based on Change Request (CR) 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS Fee Schedule. Be sure billing staff are aware of this update.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)); and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: DMERCs and DME MACS will use the 2007 PEN fee schedule payment amounts to pay claims for items furnished from January 1 through December 31, 2007.

Deleted HCPCS Codes

The following HCPCS codes are being **deleted** from the HCPCS effective January 1, 2007, and are therefore being removed from the DMEPOS and PEN fee schedule files.

A4348	A4359	A4462
A4632	E0164	E0166
E0180	E0701	E0977
E0997 thru E0999	E2320	K0090 thru K0097
K0099	L0100	L0110
L3902	L3914	L6700
L6705	L6710	L6715
L6720	L6725	L6730
L6735	L6740	L6745
L6750	L6755	L6765
L6770	L6775	L6780

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L6790	L6795	L6800
L6806 thru L6809	L6825	L6830
L6835	L6840	L6845
L6850	L6855	L6860
L6865	L6867	L6868
L6870	L6872	L6873
L6875	L6880	L7010
L7015	L7020	L7025
L7030	L7035	

Added HCPCS

The HCPCS codes listed below are being **added to the HCPCS** on January 1, 2007:

A4461	A4463	A4559
A4600	A4601	A8000
A8001	A8002	A8003
A8004	A9279	E0676
E0936	E2373 thru E2377	E2381 thru E2396
K0733 thru K0737	L1001	L3806
L3808	L3915	L5993
L5994	L6611	L6624
L6639	L6703	L6704
L6706	L6707 thru L6709	L7007 thru L7009
L8690	L8691	L8695

Payment Rates for Oxygen and Oxygen Equipment

As part of this fee schedule update, the Centers for Medicare & Medicaid Services (CMS) is implementing national monthly payment rates for oxygen and oxygen equipment effective for claims with dates of service on or after January 1, 2007. The 2007 national monthly payment rates are listed in the table below. As a result of these changes, CMS is revising the fee schedule amounts for HCPCS codes E1405 and E1406. Since 1989, the fees for HCPCS codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer HCPCS codes E0585 and E0570, respectively.

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As part of these changes, suppliers must submit claims with both the code for stationary oxygen contents (HCPCS codes E0441 or E0442) and the code for portable oxygen contents (HCPCS codes E0443 or E0444) when billing for payment for furnishing both stationary and portable oxygen contents for beneficiary-owned gaseous or liquid stationary and portable oxygen equipment.

HCPCS Codes	Amount	Class
E0424, E0439, E1390, and E1391	$198.40	Stationary Oxygen Equipment (including stationary concentrator, liquid and gaseous equipment) and Oxygen Contents (stationary and portable)
E0431 and E0434	$31.79	Portable Equipment Only (gaseous or liquid tanks)
E1392 and K0738	$51.63	Oxygen Generating Portable Equipment (OGPE) Only
E0441 and E0442	$77.45	Oxygen Contents for Beneficiary-Owned Stationary Gaseous or Liquid Oxygen Equipment
E0443 and E0444	$77.45	Oxygen Contents for Beneficiary-Owned Portable Gaseous or Liquid Oxygen Equipment

The fee schedules for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (E.G. Mask)) are being revised as part of this update to correct calculation errors and are effective for dates of service on or after January 1, 2007.

Gap-Fill Items

The Medicare DMERCS and DME MACs will gap-fill base fee schedule amounts for each State in their region for the following new and revised HCPCS codes that will be subject to the DMEPOS fee schedules in 2007:

- Inexpensive or routinely purchased DME for HCPCS codes A8002, A8003, A8004, E2373, E2374, E2375, E2376, E2377, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395
- Capped rental DME codes of E0639 and E0640
- Prosthetics and Orthotics HCPCS codes of L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639
- Surgical Dressings HCPCS codes of A4463
- DME supplies HCPCS codes of A4559

Additional Information

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

For complete details regarding this Change Request (CR) 5417, go to http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf on the CMS Web site.

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2007 Clinical Laboratory Fee Schedule & Laboratory Services: Subject to Reasonable Charge Payment

Provider Action Needed

This article and related CR 5362 contain important information regarding:

- The 2007 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests, and
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

Key Points

Update to Fees

In accordance with §1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2007 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), §1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge.

The 2007 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2007). The affected codes for the national minimum payment amount include the following:

CPT codes:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175

HCPCS codes:

G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of

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the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with §1833(h)(4)(B)(viii) of the Act.

Access to 2007 Clinical Laboratory Fee Schedule
Internet access to the 2007 clinical laboratory fee schedule data file should be available after November 20, 2006, at http://www.cms.hhs.gov/ClinicalLabFeeSched on the Centers for Medicare & Medicaid Services (CMS) Web site.

Medicaid State agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2007 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 17, 2006, CMS hosted a public meeting to solicit input on the payment relationship between 2006 codes and new 2007 Current Procedural Terminology codes. Notice of the meeting was published in the **Federal Register** on May 26, 2006, and on the CMS Web site on June 19, 2006.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the Web site http://www.cms.hhs.gov/ClinicalLabFeeSched . Additional written comments from the public were accepted until September 26, 2006.

Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (CPT codes 36415, and HCPCS codes P9612, and P9615).

For dates of service January 1, 2007, through December 2007, the fee for clinical laboratory travel HCPCS code P9603 is $0.935 per mile and for HCPCS code P9604 is $9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. The standard mileage rate for transportation costs was increased by the Federal Government's Treasury Department to 48.5 cents a mile and this amount is incorporated into the fees for travel HCPCS codes P9603 and P9604.

The 2007 laboratory fee schedule also includes codes that have a 'QW' HCPCS modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Based on comments and data submitted, CPT codes 83037 and 83037/HCPCS modifier QW is priced by cross-walking to CPT code 82985.

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Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information

CMS advises the following:

- New CPT code 80178/HCPCS modifier QW is priced at the same rate as CPT code 80178.
- New CPT code 82107 is priced at the same rate as CPT code 83950.
- New CPT code 83698 is priced at the same rate as CPT code 83880.
- New CPT code 83913 is priced at the same rate as CPT code 83907.
- New CPT code 84443/HCPCS modifier QW is priced at the same rate as CPT code 84443.
- New CPT code 86788 is priced at the same rate as CPT code 86645.
- New CPT code 86789 is priced at the same rate as CPT code 86644.
- New CPT code 86901 is priced at the same rate as CPT code 86900.
- New CPT code 87305 is priced at the same rate as CPT code 87327.
- New CPT code 87498 is priced at the same rate as CPT code 87496.
- New CPT code 87640 is priced at the same rate as CPT code 87651.
- New CPT code 87641 is priced at the same rate as CPT code 87651.
- New CPT code 87653 is priced at the same rate as CPT code 87651.
- New CPT code 87808 is priced at the same rate as CPT code 87802.
- New HCPCS code 87808/HCPCS modifier QW is priced at the same rate as CPT code 87808.
- New HCPCS code G0394 is priced at the same rate as CPT code 82270.

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 - 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as prescribed by §1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2007 is 4.3 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual,* Chapter 23, §80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual* is located on CMS' Web site at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual,* Chapter 8, §60.3 instructs the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis.

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Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood Products: HCPCS Codes:

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, (also available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage) Chapter 3, Section 20.5-20.54:

HCPCS Codes:

P9010	P9011	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058	

NOTE: Biologic products not paid on a cost or prospective payment basis are paid based on §1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for HCPCS codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine:

CPT Codes:

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86923	86927	86930	86931
86932	86945	86950	86960	86965	86970	86971
86972	86975	86976	86977	86978	86985	

HCPCS Code:

G0267

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Reproductive Medicine Procedures: CPT Codes:

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Additional Information

For complete details regarding CR 5362, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1122CP.pdf.

Instructions for calculating reasonable charges are located in the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 23, Sections 80-80.8 at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS Web site.

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

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Splints, Casts, Dialysis Supplies, Dialysis Equipment & Certain Intraocular Lenses: 2007 Reasonable Charge Update

Provider Action Needed

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses. Providers may want to be sure their billing staff knows of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses in calendar year 2007 as required by regulations contained in 42 CFR 405.501 (http://www.gpoaccess.gov/cfr/retrieve.html).

For splints and casts, Q-codes are to be used when supplies are indicated for cast and splint purposes. Current Procedural Terminology (CPT) codes should be used as indicated in the CPT section "Application of Casts and Strapping" for the specified CPT procedure codes in the 29XXX series. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. Change Request (CR) 5282 instructs your carrier, DMERC, DME MAC, or A/B MAC to compute 2007 customary and prevailing charges for the HCPCS codes V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2005, through June 30, 2006.

Carriers, and A/B MACs will compute 2007 Inflation-Indexed Charge (IIC) amounts for the HCPCS codes V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2006.

DMERCs and DME MACs will compute 2007 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2005, through June 30, 2006. For these same codes, they will compute 2007 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2006. These tables are:

Dialysis Supplies Billed With AX HCPCS Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

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Dialysis Supplies Billed Without AX HCPCS Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX HCPCS Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed Without AX HCPCS Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2007 based on the lower of the actual charge or the payment limits established for these codes. **Carriers, DMERCs and DME Medicare Administrative Contractors (MACs)** to will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007, through December 31, 2007. **Those 2007 payment limits are in the table at the end of this article.**

Additional Information

Instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the Medicare Claims Processing Manual (Pub. 100-04);
- Customary and prevailing charge are locate in section 80.2 and 80.4 of chapter 23 of the Medicare Claims Processing Manual (Pub 100-04); and
- The IIC (Inflation Indexed Charge) are located in section 80.6 of chapter 23 of the Medicare Claims Processing Manual (Pub. 100-04). The IIC update factor for 2007 is 4.3 percent.

You can find chapter 23 of the Medicare Claims Processing Manual (Pub. 100-04) at the following CMS Web site: http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf

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For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, or A/B MAC regarding this change. That instruction may be found on the CMS Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1118CP.pdf.

If you have any questions, please contact our office at 1-800-567-9232.

2007 Payment Limits for Splints and Casts			
HCPCS Code	**Payment Limit**	**HCPCS Code**	**Payment Limit**
A4565	$7.19	Q4025	$31.60
Q4001	$40.91	Q4026	$98.64
Q4002	$154.63	Q4027	$15.80
Q4003	$29.39	Q4028	$49.33
Q4004	$101.74	Q4029	$24.16
Q4005	$10.83	Q4030	$63.59
Q4006	$24.42	Q4031	$12.08
Q4007	$5.43	Q4032	$31.79
Q4008	$12.21	Q4033	$22.53
Q4009	$7.23	Q4034	$56.05
Q4010	$16.28	Q4035	$11.27
Q4011	$3.61	Q4036	$28.03
Q4012	$8.14	Q4037	$13.75
Q4013	$13.16	Q4038	$34.44
Q4014	$22.21	Q4039	$6.89
Q4015	$6.58	Q4040	$17.22
Q4016	$11.10	Q4041	$16.71
Q4017	$7.61	Q4042	$28.53
Q4018	$12.14	Q4043	$8.36
Q4019	$3.81	Q4044	$14.27
Q4020	$6.08	Q4045	$9.70
Q4021	$5.63	Q4046	$15.61
Q4022	$10.17	Q4047	$4.84
Q4023	$2.83	Q4048	$7.81
Q4024	$5.08	Q4049	$1.77

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January 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File & Revisions: 2006 Quarterly ASP Files

This article is effective January 1, 2007.

Provider Action Needed

This article is based on Change Request (CR) 5413 which informs Medicare contractors to download the January 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 files.

Background

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

The ASP methodology *is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and* CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

ASP Methodology

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

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance

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limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.
- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent (95%) of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA)** and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent (106%) of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after December 19, 2006, the revised April, July and October 2006 and January 2007 ASP file and ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP Webpage, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The revised files are applicable to claims based on dates of service as shown in the following table:

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Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2006	April 1, 2006 through June 30, 2006
July 2006	July 1, 2006 through September 30, 2006
October 2006	October 1, 2006 through December 31, 2006
January 2007	January 1, 2007 through March 31, 2007

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

Drugs Furnished During Filling or Refilling an Implantable Pumpor Reservoir

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

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

Additional Information

For complete details, please go to http://www.cms.hhs.gov/Transmittals/downloads/R1129CP.pdf on the CMS Web site.

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

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Ambulatory Surgical Centers (ASCs): 2007 HCPCS Codes

Impact on Providers

This article is based on Change Request (CR) 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

Background

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to:

- The lesser of the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment amount; or
- The ASC payment amount for services furnished on or after January 1, 2007.

Also, §1833(i)(1) of the Social Security Act requires that the list of payable ASC procedures be updated as least every two years.

CR 5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the CY 2007 Common Procedural Terminology (CPT). *These changes include replacing the ASC 2-digit payment group code designation next to the ASC-approved* Healthcare Common Procedure Coding System *(HCPCS) codes with an "YY" designation for these codes, which will be defined as "the procedure is approved to be performed in an ambulatory surgical center."*

CR 5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and fiscal intermediaries (FI) currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in Calendar Year (CY) 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups

The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR 5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS's notification.

You should be aware that final ASC payment rates are established after publication of the OPPS final rule and the code change update will be published as part of the OPPS final rule in the Federal Register. This publication usually occurs in late October. Shortly after publication, you can reach this rule through a link at http://www.cms.hhs.gov/center/asc.asp on the CMS Web site.

Also note that your carriers and FIs will continue to use the wage index values contained in Transmittal 51, dated February 4, 2004, to calculate payment amounts for all type of service F Healthcare Common Procedural Coding System (HCPCS) codes until further notice. This transmittal is available at http://www.cms.hhs.gov/Transmittals/downloads/R51OTN.pdf on the CMS site.

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Additional Information

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located at http://www.cms.hhs.gov/Transmittals/downloads/R1013CP.pdf on the CMS Web site. Attached to CR 5211 is the ASC List of Approved Procedures HCPCS Code Changes (deletions/additions) for January 1, 2007.

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

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Mammography Codes: New 2007 CPT Codes

Provider Action Needed

Impact to You

As part of the annual HCPCS update, CMS has assigned new 2007 Current Procedural Terminology (CPT) mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these CPT codes (77051, 77052, 77055, 77056, and 77057) will replace the current CPT codes; however the CPT code descriptors for the services are unchanged.

What You Need to Know

Failure to submit the correct codes will cause your claims to be returned and not processed.

What You Need to Do

Make sure that your billing staffs are aware of the CPT code changes.

Background

CR 5327, from which this article was taken, announces the assignment of new CPT codes for screening and diagnostic mammography services.

As part of the annual HCPCS update, CMS has assigned new 2007 CPT mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these CPT codes (77051, 77052, 77055, 77056, and 77057) will replace the current CPT codes; however the CPT code descriptors for the services are unchanged.

The following table displays the new (and old) replacement codes and their description.

2007 Screening and Diagnostic Mammography CPT Codes		
New CPT Code	**Old CPT Code**	**Description**
77051	76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (list separately in addition to code for primary procedure)
77052	76083	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography. (list separately in addition to code for primary procedure)

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New CPT Code	Old CPT Code	Description
77055	76090	Diagnostic mammography, unilateral
77056	76091	Diagnostic mammography, bilateral
77057	76092	Screening mammography, bilateral (two view film study of each breast)

Be advised that your carriers and FIs will return claims (with dates of service on or after January 1, 2007) that contain the old screening and diagnostic mammography codes. And also effective January 1, 2007, frequency standards for screening mammography will be applied to the new screening codes (CPT codes 77052 and 77057).

Additional Information

You can find more information about the new 2007 mammography CPT codes by going to CR5327, located at http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf on the CMS Web site.

There, as an attachment to that CR, you will find revised Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services) of the Medicare Claims Processing Manual (100-04).

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

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Multiple Procedure Reduction on the Technical Component (TC) of Certain Diagnostic Imaging Procedures & Cap on TC of Imaging Procedures

Provider Action Needed

Impact to You

This special edition article provides details regarding the Centers for Medicare & Medicaid Services (CMS) revised policies for the payment of the technical component (TC) of imaging procedures.

What You Need to Know

CMS has 1) modified the multiple procedure payment reduction to the TC of certain diagnostic imaging procedures and 2) implemented a procedure specific payment cap on the TC payment of imaging procedures effective January 1, 2007, as required by the Deficit Reduction Act of 2005.

What You Need to Do

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

Background

CMS is **implementing two provisions** in 2007 affecting imaging services. First, CMS is modifying the multiple procedure payment reduction on certain diagnostic imaging procedures implemented in 2006. Second, they are implementing a new provision of the Deficit Reduction Act of 2005 (DRA) which imposes a payment cap on most imaging procedures. (More information on the DRA is available at http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf on the CMS Web site. More information on the fee schedule final rules is available at http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage on the CMS Web site).

The **first CMS provision** for 2007 addresses payment for certain multiple diagnostic imaging procedures, with:

- A full payment for the first procedure, but
- A 25 percent reduction in the technical component (TC) payment for additional imaging procedures (furnished on contiguous body parts during the same session). This is a smaller reduction than the 50 percent that had previously been proposed for 2007. Table 1 below in the Additional Information Section contains a list of procedures subject to the multiple procedure payment reduction.

The **second CMS provision** limits the TC payment for most imaging procedures paid under the Medicare Physician Fee Schedule (MPFS) to the amount paid under the outpatient prospective payment system (OPPS). Table 2 below in the Additional Information Section contains a list of procedures subject to the OPPS payment cap.

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Both provisions apply to TC-only services and the TC of global services. The professional component (PC) is paid in full for all procedures.

For imaging services subject to both the multiple imaging reduction policy and the outpatient hospital cap, CMS is applying:

First, the multiple imaging adjustment, and
Second, the outpatient cap**.**

Note: Medicare carriers will display the outpatient cap fee on their Web sites.

Additional Information
If you have any questions, please contact your carrier at their toll-free number, which may be found on the CMS Web site at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site

Table 1
Diagnostic Imaging Services Subject to the Multiple Procedure Payment Reduction

Diagnostic Imaging Services	
Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical)	
CPT Code	**Descriptor**
76604	Us exam, chest, b-scan
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)	
CPT Code	**Descriptor**
71250	Ct thorax w/o dye
71260	Ct thorax w/ dye

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Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) continued	
CPT Code	**Descriptor**
71270	Ct thorax w/o & w/ dye
71275	Ct angiography, chest
72191	Ct angiography, pelv w/o & w/ dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/ dye
72194	Ct pelvis w/o & w/ dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/ dye
74170	Ct abdomen w/o & w/ dye
74175	Ct angiography, abdom w/o & w/ dye
75635	Ct angio abdominal arteries
0067T	Ct colonography; dx
Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)	
CPT Code	**Descriptor**
70450	Ct head/brain w/o dye
70460	Ct head/brain w/ dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/ dye
70482	Ct orbit/ear/fossa w/o & w/ dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/ dye
70488	Ct maxillofacial w/o & w/ dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/ dye
70492	Ct soft tissue neck w/o & w/ dye
70496	Ct angiography, head
70498	Ct angiography, neck

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Family 4 MRI and MRA (Chest/Abd/Pelvis)	
CPT Code	**Descriptor**
71550	Mri chest w/o dye
71551	Mri chest w/ dye
71552	Mri chest w/o & w/ dye
71555	Mri angio chest w/ or w/o dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/ dye
72197	Mri pelvis w/o &w/ dye
72198	Mri angio pelvis w/ or w/o dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/ dye
74183	Mri abdomen w/o and w/ dye
74185	Mri angio, abdom w/ or w/o dye
Family 5 MRI and MRA (Head/Brain/Neck)	
CPT Code	**Descriptor**
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/ dye
70543	Mri orbit/face/neck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiography head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiography neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
Family 6 MRI and MRA (spine)	
CPT Code	**Descriptor**
72141	Mri neck spine w/o dye

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Family 6 MRI and MRA (spine) continued	
CPT Code	**Descriptor**
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
Family 7 CT (spine)	
CPT Code	**Descriptor**
72125	CT neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
Family 8 MRI and MRA (lower extremities)	
CPT Code	**Descriptor**
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lower ext w/ & w/o dye
73721	Mri joint of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint of lwr extr w/o & w/dye
73725 – MRA	Mr angio lower ext w or w/o dye

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Family 9 CT and CTA (lower extremities)	
CPT Code	**Descriptor**
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lower extremity w/o & w/dye
73706	Ct angio lower ext w/o & w/dye
Family 10 MR and MRI (upper extremities and joints)	
CPT Code	**Descriptor**
73218	MRI upper extr w/o dye
73219	MRI upper extr w/dye
73220	MRI upper extremity w/o & w/dye
73221	MRI joint upper extr w/o dye
73222	Mri joint upper extr w/dye
73223	Mri joint upper extr w/o & w/dye
Family 11 CT and CTA (upper extremities)	
CPT Code	**Descriptor**
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct upper extremity w/o & w/dye
73206	Ct angio upper extr w/o & w/dye

Table 2

Addendum F CPT/HCPCS Imaging Codes Defined by DRA 5102(b)

CPT Code	Short Descriptor
31620	Endobronchial us add-on
37250	Iv us first vessel add-on
37251	Iv us each add vessel add-on
51798	Us urine capacity measure
70010	Contrast x-ray of brain

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CPT Code	Short Descriptor
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex

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CPT Code	Short Descriptor
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye

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CPT Code	Short Descriptor
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine

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CPT Code	Short Descriptor
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye

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CPT Code	Descriptor
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72293	Percut vertebroplasty, ct
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder

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CPT Code	Short Descriptor
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips

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CPT Code	Short Descriptor
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen

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CPT Code	Short Descriptor
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on

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CPT Code	Short Descriptor
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74350	X-ray guide, stomach tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75552	Heart mri for morph w/o dye

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CPT Code	Short Descriptor
75553	Heart mri for morph w/dye
75554	Cardiac MRI/function
75555	Cardiac MRI/limited study
75556	Cardiac MRI/flow mapping
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs

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CPT Code	Short Descriptor
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy

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CPT Code	Short Descriptor
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
76000	Fluoroscope examination
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen

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CPT Code	Short Descriptor
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76140	X-ray consultation
76150	X-ray exam, dry process
76350	Special x-ray contrast study
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76390	Mr spectroscopy
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen

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CPT Code	Short Descriptor
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study
76880	Us exam, extremity

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CPT Code	Short Descriptor
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct

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CPT Code	Short Descriptor
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density/v-fracture
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd

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CPT Code	Short Descriptor
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase

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CPT Code	Short Descriptor
78320	Bone imaging (3D)
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78478	Heart wall motion add-on
78480	Heart function add-on
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging

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CPT Code	Short Descriptor
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78610	Brain flow imaging only
78615	Cerebral vascular flow image
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78704	Imaging renogram
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78715	Renal vascular flow exam

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CPT Code	Short Descriptor
78730	Urinary bladder retention
78740	Ureteral reflux study
78760	Testicular imaging
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
78890	Nuclear medicine data proc
78891	Nuclear med data proc
93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93313	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93316	Echo transesophageal
93317	Echo transesophageal

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CPT Code	Short Descriptor
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0028T	Dexa body composition study

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CPT Code	Short Descriptor
0042T	Ct perfusion w/contrast, cbf
0066T	Ct colonography;screen
0067T	Ct colonography;dx
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on
0152T	Computer chest add-on
HCPCS Codes	**Short Descriptor**
G0120	Colon ca scrn; barium enema
G0122	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0219	Pet imaging whole body; melanoma for non-covered items
G0235	PET not otherwise specified
G0275	Renal angio, cardiac cath
G0278	Iliac art angio,cardiac cath
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

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Technical Component (TC) of Radiology & Pathology Laboratory Services Provided to Hospital Patients: CWF Duplicate Claim Edits

Provider Types Affected

Radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and non-physician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Background

Current Medicare billing practices allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the Prospective Payment System (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007, for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

Key Points

Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.

Effective for claims received on or after April 1, 2007, Medicare will reject/deny reject a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient

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bill (bill types 13X and 85X0 previously processed by Medicare.
If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use Remittance Advice Reason Code 109 "Claim not covered by this payer/contractor." when denying a service line item.

Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same Remittance Advice Reason Code of 109 will be used in such cases.

Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use Remittance Advice Reason Code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.

Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

Additional Information

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

For complete details regarding this CR, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1098CP.pdf on the CMS Web site.

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One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA): Resulting from a Referral from an Initial Preventive Physical Examination

Note: This article was changed on December 8, 2006, to add emphasize that this coverage is for a one-time only service and it must also be as a result of a referral from an initial preventive physical exam and is also subject to other limitations as discussed in this article and in CR 5235.

Background

This article and related CR 5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an Initial Preventive Physical Examination (IPPE) and subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

Key Points

Effective for dates of service on and after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:

- Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE) (See *MLN Matters* article MM 3638 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf for more details on the IPPE.)
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services.
- Has not been previously furnished such an ultrasound screening under the Medicare Program
- Is included in at least one of the following risk categories:
    1. Has a family history of abdominal aortic aneurysm;
    2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
    3. Is a patient, who manifests other risk factors in a patient category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

Payment

The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.

If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.

- Short Descriptor: Ultrasound exam AAA screen
- Modifiers: HCPCS TC or CPT 26 are optional
- Payment is under the Medicare Physician Fee Schedule (MPFS).

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FIs will pay for the AAA screening only when the services are performed in a hospital, including a **CAH, IHS facility, an SNF, RHC, or FQHC** and submitted on one of the following types of bills (TOBs): **12X, 13X, 22X, 23X, 71X, 73X, 85X.**

The following table describes the payment methodology Medicare will use for AAA Screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12X, 13X	OPPS
Method I and Method II Critical Access Hospitals (CAHs)	12X and 85X	101% of reasonable cost
IHS providers	13X, revenue code 051X	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12X, revenue code 024X	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85X, revenue code 051X	101% of the all-inclusive facility specific per visit rate
IHS CAHs	12X, revenue code 024X	101% of the all-inclusive facility specific per diem rate
SNFs **	22X, 23X	Non-facility rate on the MPFS
RHCs*	71X, revenue code 052X	All-inclusive encounter rate
FQHCs*	73X, revenue code 052X	All-inclusive encounter rate
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	94% of provider submitted charges or according to the terms of the Maryland Waiver

*If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

** The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22x bill type. Screening services provided by other provider types must be reimbursed by the SNF.

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Implementation

The implementation date for this instruction is January 2, 2007.

Information Regarding Advance Patient Notices: Medicare contractors will deny an AAA screening service billed more than one in a patient's lifetime.

If a second HCPCS code G0389 is billed for AAA for the same patient or if any of the other statutory criteria for coverage listed in Section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under Section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the patient has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

Additional Information

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change can be found on CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf. The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR 5235.

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

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Infrared Therapy Devices

Provider Types Affected

Physicians, suppliers, and providers who submit claims for the use of infrared therapy devices for treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare patients.

Impact on Providers

This article is based on Change Request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a National Coverage Determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is non-covered for the treatment,** including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare patients.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are non-covered** as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
  - 250.60-250.63,
    354.4, 354.5, 354.9,
  - 355.1-355.4,
  - 355.6-355.9
  - 356.0, 356.2-356.4, 356.8-356.9,
  - 357.0-357.7,
  - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
  - 707.00-707.07, 707.09-707.15, 707.19,
  - 870.0-879.9,
  - 880.00-887.79,
  - 890.0-897.7, or
  - 998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.

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- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

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

Please see the two transmittals associated with CR 5421 for complete details. The first is the national coverage determination transmittal, located at http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf on the CMS Web site. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1127CP.pdf on the CMS site.

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Ambulance FAQ: Chronic Renal Disease

Question: Is it OK to mark "Parent Claim" on every CRD Ambulance claim that I submit?

Answer: No. Using "Parent Claim" on every claim you submit will cause problems for both you and Palmetto GBA. Examples of such problems are:

- If "Parent Claim" is used on every claim submitted, then your payment will be delayed. All "Parent Claims" are sent to the Medical Review Department for clinician review. When this process occurs, it results in longer additional processing days for your claims. Claims that do not require clinician review can be processed more quickly.

- If "Parent Claim" is used on a claim that is not a "Parent Claim" and no supporting documentation is submitted with the claim, we will send you a letter requesting documentation to support the medical necessity for the service that was rendered. We will not process the claim any further until the documentation is received or 45 days from the date of the letter, whichever is first. After documentation is received, it is sent to our Medical Review department for clinician review, which results in a longer number of days to process your claim.

- If "Parent Claim" is used on claims for patients that have been previously identified as "indefinite" and the documentation no longer supports that the transports should be allowed indefinitely, the coverage status may change. It is important to note that, once you have received an "indefinite" approval for a beneficiary, you will never need to submit another "Parent Claim" to Palmetto GBA unless that beneficiary's condition changes for the better.

For instructions on submitting your "Parent Claim" correctly please visit http://www.PalmettoGBA.com/boh (for Ohio suppliers) or http://www.PalmettoGBA.com/bwv (for West Virginia suppliers) and click on Ambulance (under Articles), then Chronic Renal Disease Repetitive Ambulance Transports & Physician Certification Statement Form.

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Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered the Medicare coverage policy for TEB for drug-resistant hypertension and decided to retain current coverage as written in section 20.16 of the National Coverage Determinations (NCD) Manual.

Effective for dates of service on and after November 24, 2006, the current policies for cardiac output monitoring by TEB listed at section 20.16 of the NCD Manual will remain the same. Medicare A/B MACs and carriers will continue to make reasonable and necessary determinations for the use of TEB related to drug-resistant hypertension only. All other coverage and non-coverage policies at section 20.16 remain in effect.

Additional Information

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

For complete details regarding this Change Request (CR) **including the revised section of 20.16 of the NCD** manual, please go to http://www.cms.hhs.gov/transmittals/downloads/R63NCD.pdf on the CMS Web site.

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Gastric Electrical Stimulation: Coverage Article

Effective for services on or after January 1, 2007:

Indications:
The U.S. Food and Drug Administration (FDA) has designated the Enterra™ Therapy System as a Humanitarian Use Device. A Humanitarian Use Device is a medical device intended for rare conditions affecting fewer than 4000 patients per year.

The FDA has approved the Enterra™ Therapy gastric electrical stimulation device for treatment of the symptoms of severe and medically intractable (drug refractory) diabetic or idiopathic gastroparesis. Humanitarian Use Device requirements, including prior approval by the hospital Institutional Review Board, must be met.

Limitations:
GES is not covered for non-FDA approved indications.

Documentation Requirements:
The medical record must document that all coverage criteria have been met.

CPT codes:
- 43647 – Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
- 43648 – Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
- 43881 – Implantation or replacement of gastric neurostimulator electrodes, antrum, open
- 43882 – Revision or removal of gastric neurostimulator electrodes, antrum, open
- 64590 – Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
- 64595 – Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

Covered ICD-9 codes:
- 250.60 – 250.63 – Diabetes with neurological manifestations, Type II or unspecified type, not stated as uncontrolled – diabetes with neurological manifestations, Type I (Juvenile Type), uncontrolled.
- 536.3- Gastroparesis

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Laboratory Competitive Bidding Demonstration

Note: This article was changed on November 27, 2006, to specify that the only hospitals affected were those that bill (TOB) 14X. All other information remains the same. Also, the article was previously published as MM 5205, based on CR 5205, which discussed the initial phase of implementing this demonstration.

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and Change Request (CR) 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore **exempt** from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing **are not included in the demonstration**, **except** where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

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Passive Laboratories

Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will **not be required** to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of $100,000.

Passive laboratory firms exceeding the annual ceiling of $100,000 will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considers "passive-ESRD" laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007, through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled "winners."

Non-Winners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "non-winners."

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

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Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing file identifying the zip codes included in the first CBA. Also, in that same timeframe,

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CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (non-covered charges);
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor*.); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.). Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a CPT modifier 90 submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

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Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is April 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.pdf on the CMS Web site.

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

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New Waived Tests

Provider Action Needed

This article is based on Change Request (CR) 5404 which informs carriers and A/B MACS of new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test they perform. Laboratory claims are currently edited at the CLIA certificate level in order to ensure that the Centers for Medicare & Medicaid Services (CMS) only pays for laboratory tests categorized as waived complexity under CLIA (for facilities with a CLIA certificate of waiver).

New waived tests are approved by the FDA on a flow basis, and the tests are valid as soon as they are approved. The new waived tests announced by CR 5404 are in the following table:

Newly Added CLIA Waived Tests	Effective Date	**Codes & Modifier**
Immunostics, Inc., hema-screen Specific Immunochemical Fecal Occult Blood Test	June 15, 2006	CPT code 82274 & HCPCS modifier QW HCPCS code G0328 & modifier QW
Gryphus Diagnostics BVBlue	June 30, 2006	CPT code 87899 & HCPCS modifier QW
ESA Biosciences LeadCare II Blood Lead Testing System (whole blood)	September 18, 2006	CPT code 83655 & HCPCS modifier QW

Note: The Current Procedural Terminology (CPT) codes for these new waived tests must have the HCPCS modifier QW to be recognized as a waived test. Also, for 2007, the new CPT code 87808 with HCPCS modifier QW (Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis) replaces CPT code 87899 with HCPCS modifier QW that was assigned to the Genzyme OSOM Trichomonas Rapid Test.

Additional Information

For complete details, please see the official instruction, CR 5404, issued to your carrier or A/B MAC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R1115CP.pdf. The attachment to CR 5404 includes the list of tests granted waived status under CLIA, and the tests mentioned on the first page of the attachment (i.e., CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, 85651 and HCPCS code G0394) do not require a QW HCPCS modifier to be recognized as a waived test.

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As mentioned in Change Request 5292 (Transmittal 1062, dated September 22, 2006), the HCPCS code **G0107** (Colorectal Cancer Screening; fecal-occult blood test, 1-3 simultaneous determinations) will be retired effective January 1, 2007, and has been replaced with CPT code 82270 [Blood, occult, by peroxidase activity (e.g., Guaiac) qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)].

For 2007, the new HCPCS code **G0394** is for Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection). This code does not require a QW HCPCS modifier.

To view CR 5292 (Transmittal 1062, dated September 22, 2006), please go to http://www.cms.hhs.gov/Transmittals/downloads/R1062CP.pdf.

The MLN Matters article based on CR 5292 is located on CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5292.pdf.

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

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Outpatient Therapy Cap Exceptions Clarifications

Note: This article was revised on December 4, 2006, to reflect the correct effective and implementation dates as described in CR 5271, which CMS recently revised. While CR 5271 also reflects effective and implementation dates in January 2007 for Medicare system changes, the information in this article clarifies existing processes.

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes. It also reminds you that the exception process stops after December 31, 2006.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed Financial limitations on Medicare covered therapy services (therapy caps), that were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were re-implemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary. **This process ends after December 31, 2006.**

Review of this exception process

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

Exception Processes fall into two categories:

1) Automatic Process Exceptions

Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual,* Publication 100-04, Chapter 5, (as revised by CR 5271) for exception from the therapy cap for 2006.

2) Manual Process Exceptions

Medicare beneficiaries may be request an exception using the manual process for exception from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the criteria for automatic exceptions.

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The clarifications to questions generated from CR 4364

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual,* Pub. 100-04, Chapter 5, (as revised by CR5271)
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted for services provided in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request for services provided in 2006.
4. Must reply as soon as practicable to a request for exception for services provided in 2006. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process for services provided in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that **may or may not be on the list** in the *Medicare Claims Processing Manual* in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.
9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals.
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for re-evaluation **only** because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.
13. Will require clinicians to write Progress Reports at least during each Progress Report Period. Note that required elements of the Progress Report that are written into the Treatment Notes or in a Plan of Care may acceptably fulfill the requirement for a Progress Report. In these instances, a separate Progress Report is not required.

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14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.
15. Will continue to use Medicare Summary Notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."
16. Will continue to enforce Local Coverage Determinations (LCDs).

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

ICD-9 CODE	DESCRIPTION
V43.64	Joint Replacement, Hip
V43.65	Joint Replacement, Knee
V43.61	Joint Replacement, Shoulder
V49.63-49.67	Upper Limb Amputation Status
V49.73-49.77	Lower Limb Amputation Status
250.00 – 250.93	Diabetes Mellitus*
278.01-278.02	Overweight, Obesity, and Other Hyperalimentation *
290.0-290.43	Dementias*
294.0-294.9	Persistent Mental Disorders Due To Conditions Classified Elsewhere*
311	Depressive Disorder Nec*
323.0-323.9	Encephalitis, Myelitis, and Encephalomyelitis*
331.0-331.9	Other Cerebral Degenerations
332.0-332.1	Parkinson's Disease
333.0-333.99	Other Extrapyramidal Diseases and Abnormal Movement Disorders
334.0-334.9	Spinocerebellar Disease
335.0-335.9	Anterior Horn Cell Disease

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ICD-9 CODE	DESCRIPTION
336.0-336.9	Other Diseases Of Spinal Cord
337.20-337.29	Reflex Sympathetic Dystrophy
340	Multiple Sclerosis
342.00-342.92	Hemiplegia and Hemiparesis
343.0-343.9	Infantile Cerebral Palsy
344.00-344.9	Other Paralytic Syndromes
348.0-348.9	Other Conditions Of Brain
349.0-349.9	Other And Unspecified Disorders Of The Nervous System
353.0-357.7	Neuropathies See Code Book For Details
359.0-359.9	Muscular Dystrophies and Other Myopathies
386.00-386.9	Vertiginous Syndromes and Other Disorders Of Vestibular System*
401.0-401.9	Essential Hypertension*
402.00-402.91	Hypertensive Heart Disease*
414.00-414.9	Other Forms Of Chronic Ischemic Heart Disease*
415.0-415.19	Acute Pulmonary Heart Disease*
416.0-416.9	Chronic Pulmonary Heart Disease*
427.0-427.9	Cardiac Dysrhythmias*
428.0-428.9	Congestive Heart Failure*
430-432.9	Intracranial Hemorrhages
433.00-434.91	Occlusion and Stenosis Of Precerebral and Cerebral Arteries (**For Occlusion Only**)
436	Acute, But Ill-Defined, Cerebrovascular Disease
437.0-437.9	Other And Ill-Defined Cerebrovascular Disease
438.0-438.9	Late Effects Of Cerebrovascular Disease
443.0-443.9	Other Peripheral Vascular Disease*
453.0-453.9	**Other Venous Embolism and Thrombosis***
457.0-457.1	Postmastectomy Lymphedema Syndrome and Other Lymphedema
478.30-478.5	Disesases Of Vocal Cords Or Larynx
486	Pneumonia, Organism Unspecified*

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ICD-9 CODE	DESCRIPTION
490-496	**Chronic Obstructive Pulmonary Diseases***
710.0-710.9	Diffuse Diseases Of Connective Tissue
707.00-707.9	Chronic Ulcer Of Skin*
711.00-711.99	Arthropathy Associated With Infections*
713.0-713.8	Arthropathy Associated With Other Disorders Classified Elsewhere*
714.0-714.9	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies*
715.09	Osteoarthritis and Allied Disorders, Multiple Sites
715.11	Osteoarthritis, Localized, Primary, Shoulder Region
715.15	Osteoarthritis, Localized, Primary, Pelvic Region and Thigh
715.16	Osteoarthritis, Localized, Primary, Lower Leg
715.91	Osteoarthritis, Unspecified Id Gen. Or Local, Shoulder
715.96	Osteoarthritis, Unspecified If Gen. Or Local, Lower Leg
718.44	Contracture Of Joint, Hand
718.49	Contracture Of Joint, Multiple Sites
719.7	Difficulty Walking*
721.91	Spondylosis With Myelopathy
723.4	Other Disorders Of The Cervical Region, Brachia Neuritis Or Radiculitis Nos
724.02	Spinal Stenosis, Lumbar Region
724.3	Other and Unspecified Disorders Of The Back, Sciatica*
724.4	**Other and Unspecified Disorders Of The Back, Thoracic Or Lumbosacral Neuritis Or Radiculitis, Unspecified***
726.10-726.19	Rotator Cuff Disorder and Allied Syndromes
727.61-727.62	Rupture Of Tendon, Nontraumatic
733.00	Osteoporosis With Wedging Of Vertebra
780.93	Memory Loss
781.2	Abnormality Of Gait
781.3	Lack Of Coordination
781.8	Neurologic Neglect Syndrome

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ICD-9 CODE	DESCRIPTION
781.92	**Symptoms Involving Nervousand Musculoskeletal Symptoms, Abnormal Posture***
784.3-784.9	Aphasia and Other Speech Disturbances
787.2	Dysphagia
806.00-806.9	Fracture Of Vertebral Column With Spinal Cord Injury
810.00-810.13	Fracture Of Clavicle
811.00-811.19	Fracture Of Scapula
812.00-.812.59	Fracture Of Humerus
813.00-813.93	Fracture Or Radius and Ulna
820.00-820.9	Fracture Of Neck Of Femur
821.00-821.39	Fracture Of Other and Unspecified Parts Of Femur
828.0-828.1	Multiple Fractures Involving Both Lower Limbs, Lower With Upper Limb, and Lower Limb(S) With Rib(S) And Sternum
852.00-852.59	Subarachnoid, Subdural, and Extradural Hemorrhage, Following Injury
853.00-853.19	Other And Unspecified Intracranial Hemorrhage Following Injury
854.00-854.19	Intracranial Injury Of Other and Unspecified Nature
881.00-881.22	Open Wound Of Elbow, Forearm, and Wrist
882.0-882.2	Open Wound Of Hand With Tendon Involvement
884.0-884.2	Multiple and Unspecified Open Wound Of Upper Limb With Tendon Involvement
887.0 – 887.7	Traumatic Amputation Of Arm and Hand (Complete) (Partial)
897.0-897.7	Traumatic Amputation Of Leg(S) (Complete) (Partial)
941.00-949.5	Burns
950.0-952.9	Injury To Optic and Other Cranial Nerves, Spinal Cord
959.01	Head Injury

*** Denotes Complexities**

Additional Information

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

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

These manual revisions include numerous additional changes and clarifications.

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

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Cavernous Nerves Electrical Stimulation with Penile Plethysmography

Provider Action Needed

Impact to You

Effective for claims with dates of service on or after August 24, 2006, Medicare will not pay for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare patients undergoing nerve-sparing prostatic or colorectal surgical procedures.

What You Need to Know

CR 5294, from which this article is taken, announces the results of a national coverage determination (NCD) addressing Cavernous Nerves Electrical Stimulation with Penile Plethysmography performed for Medicare patients undergoing nerve-sparing prostatic or colorectal surgical procedures. It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare patients undergoing these procedures.

What You Need to Do

Make sure that your billing staffs are aware of this NCD.

Background

The direct application of electrical stimulation with penile plethysmography (also referred to as cavernosal nerve mapping) may be performed, in nerve-sparing prostatic and colorectal surgical procedures, to assess the integrity and function of the cavernous nerves.

Through either an open or laparoscopic approach, the surgeon can assess the function of the cavernous nerves by stimulating, with an electrical nerve stimulator, the most distal end of the nerve that can be located. A functioning and stimulated nerve will trigger blood flow either into or out of the penis, which can be detected via a penile plethysmography sensor fitted around the penis and connected to a nerve stimulator control unit. If the nerves are intact, cavernous blood flow will cause slight changes in penile girth, which the sensor can detect. The presence (and degree) of a response may be used to provide the surgeon with a more realistic assessment of the chance of the patient regaining potency and assist in choosing appropriate therapy.

Heretofore, local Medicare carriers/FIs had the discretion to cover this test whenever it was determined to be medically necessary for the individual patient, because a national coverage determination (NCD) or national Medicare coverage policy had not been issued. However, on December 9, 2005, a request for review of this test initiated a national coverage analysis.

CR 5294, from which this article is taken, announces the results of this NCD. It provides that CMS has reviewed the evidence and determined that:

1. Cavernous Nerves Electrical Stimulation with Penile Plethysmography is not reasonable and necessary for Medicare patients undergoing nerve-sparing prostatic or colorectal surgical procedures, and

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2. This test is **noncovered** under Medicare (as specified **the Medicare National Coverage Manual (100-03,** Section 160.26 (**Cavernous Nerves Electrical Stimulation with Penile Plethysmography)**.

Effective with claims with dates of service on or after August 24, 2006, your FIs and carriers will not pay for these services.

Physicians should use CPT code 55899 to bill this for test. Your FIs and carriers will suspend claims containing this code to determine whether this test is the service being billed, and will deny the line item associated with it, using Medicare Summary Notice 21.11 (This test was not covered by Medicare at the time you received it).

You should be aware that carriers will not search for, and adjust, claims for tests that have been paid prior to January 8, 2007, but they will adjust claims brought to their attention. Further, physicians and hospitals should, as appropriate:

1. Issue the appropriate liability notice for Medicare patients having this test;
2. Include the following language when issuing an Advanced Beneficiary Notice (ABN):
   - ***Under "Items or Service" Section:*** *Cavernous Nerves Electrical Stimulation with Penile Plethysmography.*
   - ***Under "Because" Section:*** *As specified in section 160.26 of Medicare NCD Manual, Medicare will not pay for this test as it is not reasonable and necessary for Medicare patients undergoing nerve-sparing prostatic or colorectal surgical procedures.* and/or
3. Issue a hospital Issued Notice of Noncoverage (HINN).

If a physician does not issue an ABN, the physician is liable for the service.

Additional Information

You can find more information about payment for Cavernous Nerves Electrical Stimulation with Penile Plethysmography by going to CR 5294, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R61NCD on the CMS site. You will find revised section 160.26 (**Cavernous Nerves Electrical Stimulation with Penile Plethysmography) of the** *Medicare National Coverage Manual* **(Publication 100-03) as an attachment to this CR.**

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

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

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

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

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

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

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Local Coverage Determination Updates

LCD	Change	Effective Date
Bone Mass Measurement 2001-37LR14	2007 Annual CPT/HCPCS update. Deletion of CPT codes 76070, 76071, 76075, 76076, 76077 and 76078. Addition of CPT codes 77078, 77079, 77080, 77081, 77082, and 77083.	1/1/07
Cancer Chemotherapy & Chemotherapeutic Agents 2002-29LR29	Addition of ICD-9 codes 180.0 - 180.9 as supporting medical necessity of HCPCS code J9390 (Vinorelbine Tartrate).	11/8/06
Cancer Chemotherapy and Chemotherapeutic Agents 2002-29LR29.1	2007 Annual CPT/HCPCS update. Replace HCPCS code J9999 for DACOGEN with HCPCS code J0894.	1/1/07
Chemotherapy & Biologicals: Draft 2002-29LR30	Revised policy posted for comment & notice on 12/06/06.	4/1/07
Paravertebral Facet Joint Block 2000-31LR6	2007 Annual CPT/HCPCS update. Deletion of CPT code 76005 and addition of CPT code 77003.	1/1/07
Percutaneous Transluminal Angioplasty 2001-10LR8	2007 Annual CPT/HCPCS update. Addition of HCPCS code G0392 for ICD-9 codes 250.70-250.73, 435.2, 440.21-440.24, 442.0, 444.21, 447.1, 996.1, 996.62, and 996.73 and HCPCS code G0393 for ICD-9 codes 440.30-440.32, 451.11-451.89, 453.40, 453.41, 453.42, 453.8, 456.0, 456.1, 456.20, 456.21, 459.2, 459.89, 789.5, 996.1, 996.59, 996.60, 996.62, 996.73, 996.74, and 997.4.	1/1/07
T-wave Alternans Testing 2002-28LR4	Addition of ICD-9 codes 411.1, 425.0 - 425.3, 425.5 and 425.7 as supporting medical necessity for CPT code 93025.	1/1/07
Vertebroplasty/Kyphoplasty 2000-36LR7	2007 Annual CPT/HCPCS update. Deletion of CPT code 76012 and 76013. Addition of CPT codes 72291 and 72292.	1/1/07
Wireless Capsule Endoscopy Draft 2002-48LR6	Revised policy posted for comment & notice on 12/06/06. Revision includes 2007 Annual CPT/HCPCS update. Addition of CPT code 91111 as a non-covered service.	4/1/07

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Coverage Article Updates

Self-Administered Drug Exclusion Article	2007 Annual CPT/HCPCS update. HCPCS code J1324 replaced HCPCS code J3490 for Enfuvirtide.	1/1/07
Paravertebral Facet Joint Block	2007 Annual CPT/HCPCS update. Deletion of CPT code 76005 and addition of CPT code 77003.	1/1/07
Cancer Chemotherapy & Chemotherapeutic Agents Coding Guidelines	Added requirements of National Drug Code (NDC) number to be entered in block 19 for unlisted or "NOC" procedure codes.	1/1/07
Off-Label Cancer Chemotherapy Use	Added requirements of National Drug Code (NDC) number to be entered in block 19 for off-label procedure codes.	1/1/07

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-03 Medicare National Coverage Determinations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 63	Date: DECEMBER 15, 2006
	Change Request 5414

NOTE: This instruction was issued earlier today contained an incorrect implementation date on the Business Requirement. The instruction has been revised and all other information remains the same.

SUBJECT: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)

I. SUMMARY OF CHANGES: Effective November 24, 2006, after reconsideration of Medicare policy, CMS will continue current Medicare coverage policy of TEB

NEW/REVISED:
EFFECTIVE DATE: NOVEMBER 24, 2006
IMPLEMENTATION DATE: January 16, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/20.16 Cardiac Output Monitoring By Thoracic Electrical Bioimpedance (TEB) - Various Effective Dates Below

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

****Unless otherwise specified, the effective date is the date of service.***

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Attachment - Business Requirements

Pub. 100-03	Transmittal: 63	Date: December 15, 2006	Change Request: 5414

NOTE: This instruction was issued earlier today contained an incorrect implementation date on the Business Requirement. The instruction has been revised and all other information remains the same.

SUBJECT Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)

Effective Date: November 24, 2006
Implementation Date: January 16, 2007

I. GENERAL INFORMATION

A. Background: Following the reconsideration of Medicare coverage policy for Thoracic Electrical Bioimpedance (TEB) for drug-resistant hypertension, CMS has decided to retain current coverage at section 20.16 of the NCD Manual.

B. Policy: CMS will continue to permit contractors to make reasonable and necessary determinations for the use of TEB related to drug-resistant hypertension only. All other coverage and non-coverage policies at section 20.16 remain in effect.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5414.1	Effective for dates of service on and after 11/24/06, contractors shall continue to use the current policies for cardiac output monitoring by TEB at 20.16 of the NCD Manual to process claims.	X			X							

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III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5414.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X			X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Francina Spencer, Francina.spencer@cms.hhs.gov , 410-786-4614 (coverage), Pat Brocato-Simons, patricia.brocatosimons@cms.hhs.gov , 410-786-0261 (coverage)

Post-Implementation Contact(s): Appropriate RO

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VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare National Coverage Determinations Manual

Chapter 1, Part 1 (Sections 10 – 80.12)

Coverage Determinations

Table of Contents

(Rev. 63, 12-15-06)

20.16 - Cardiac Output Monitoring By Thoracic Electrical Bioimpedance (TEB) – *Various Effective Dates Below*

20.16 - Cardiac Output Monitoring By Thoracic Electrical Bioimpedance (TEB) – *Various Effective Dates Below*

(Rev. 63, Issued: 12-15-06; Effective: 11-24-06; Implementation: 01-16-07)

A. General

Thoracic electrical bioimpedance (TEB) devices, a form of plethysmography, monitor cardiac output by non-invasively measuring hemodynamic parameters, including: stroke volume, systemic vascular resistance, and thoracic fluid status. Under *a* previous coverage determination, effective *for services performed on and after* July 1, 1999, use of TEB was covered for the "noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease." In reconsidering this policy, *the Centers for Medicare & Medicaid Services (*CMS*)* concluded that this use was neither sufficiently defined nor supported by available clinical literature to offer the guidance necessary for practitioners to determine when TEB would be covered for patient management. Therefore, CMS revised its coverage policy language in response to a request for reconsideration to offer more explicit guidance and clarity for coverage of TEB based on a complete and updated literature review.

B. *Nationally* Covered Indications

Effective for services performed on and after January 23, 2004, TEB is covered for the following uses:

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1. Differentiation of cardiogenic from pulmonary causes of acute dyspnea when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
2. Optimization of atrioventricular (A/V) interval for patients with A/V sequential cardiac pacemakers when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
3. Monitoring of continuous inotropic therapy for patients with terminal congestive heart failure, when those patients have chosen to die with comfort at home, or for patients waiting at home for a heart transplant.
4. Evaluation for rejection in patients with a heart transplant as a predetermined alternative to a myocardial biopsy. Medical necessity must be documented should a biopsy be performed after TEB.
5. Optimization of fluid management in patients with congestive heart failure when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

C. *Nationally* Non-Covered Indications

1. TEB is non-covered when used for patients:

a. With proven or suspected disease involving severe regurgitation of the aorta;
b. With minute ventilation (MV) sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker;
c. During cardiac bypass surgery; or,
d. In the management of all forms of hypertension (with the exception of drug-resistant hypertension as outlined *below*).

2. All other uses of TEB not otherwise specified remain non-covered.

D. Other

Contractors have discretion to determine whether the use of TEB for the management of drug-resistant hypertension is reasonable and necessary. Drug resistant hypertension is defined as failure to achieve goal *blood pressure* in patients who are adhering to full doses of an appropriate *3*-drug regimen that includes a diuretic. *Effective November 24, 2006, after reconsideration of Medicare policy, CMS will continue current Medicare policy for TEB.*

(This NCD last reviewed November 2006.)

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Medicare Part B Refund & Overpayment Form

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

Provider Information
(Must be Completed)

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

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

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

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

Medicare Secondary Payer Reason For Overpayment

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

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

Medicare Secondary Payer (MSP)

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

Secondary Insurance:

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

Reason For Overpayment/Refund

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

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

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

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

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

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

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

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

_____

Signature: _____

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

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

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

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

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

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

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

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

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Redetermination Request for Medicare Part B Claims

For Ohio & West Virginia

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

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

General Information

Patient's name _____

Health Insurance Claim (HIC) number _____

Date of initial determination _____

CPT code(s) _____

ICD-9 code(s) _____

Performing provider number _____

Billing provider number _____

Phone number _____

Date of service _____

This is an appeal for:

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

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

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

Reason for request: _____

_____

_____

_____

Requestor (signature required): _____ Date: _____

Address: _____

_____

_____

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

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Reconsideration Request Form - QIC North (Ohio)

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

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

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

1. Name of Beneficiary: _____

2 a. Medicare Number: _____

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

3. Provider Name and Number: _____

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

5. Address of Person Appealing:

6. Item or service you wish to appeal:

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

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

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

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

11. Printed Name of Person Appealing:

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

13. Phone Number of Person Appealing: _____

Contractor Number: 00883

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

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CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

Reconsideration Request Form - QIC East (West Virginia)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. **To help us serve you better, please include a copy of the redetermination notice with your reconsideration request.**

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

1. Name of Beneficiary: _____

2. Medicare Number: _____

3. Provider Name and Number: _____

4. Person Appealing: Beneficiary Provider of Service Representative

5. Address of Person Appealing:_____
_____

6. Item or service you wish to appeal: _____

7. Date(s) of service: ____/____/____ TO ____/____/____

8. Does this appeal involve an overpayment: Yes No

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

10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:

Medical Records A copy of the Claim Treatment Plan

Certificate of Medical Necessity Office Notes / Progress Notes

11. Printed Name of Person Appealing: _____

12. Signature of Person Appealing: _____ Date: _____

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

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

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

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

TTY 1-877-391-9739

Provider Enrollment Support Line
1-866-308-5439

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

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

http://www.PalmettoGBA.com

Important Sources For You

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

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

Attention: Billing Manager

PRSRT STD
U.S. POSTAGE PAID
Columbus, Ohio
Permit No. 2141