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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

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Administrative Information

Patient Paid on Medicare Secondary Payer Claims	2
New Deadline for CMS-1500 Claim Form (08-05).....	3
Unique Physician Identification Number Registry:	
Discontinued	4-5
Medically Unlikely Edits (MUEs), July Update.....	6
Correct Coding Initiative (CCI) Edits, July Update.....	7
Stage 3 NPI Changes: Transaction 835, &	
Standard Paper Remittance Advice	8-10
Stage 2 NPI: Transaction 835 &	
Standard Paper Remittance Advice	11-13
Medigap (“Claim-Based”) Crossover Process to the	
Coordination of Benefits Contractor (COBC).....	14-16

Drugs & Biologicals

Discarded Drugs & Biologicals: Single Use	
Vial/Package.....	17
Immune Globulin HCPCS Codes Revised	18-20
Albuterol, Levalbuterol, and Reclast®:	
July 2007 Update	21-22

Electronic Data Interchange (EDI)

EDI Migration to the GPNet Front End.....	23
---	----

Education

Palmetto Place & Provider List Serv	
Registration Form.....	24-25
Free Evaluation & Management Seminars	26

Fee Schedules & Reimbursement

2007 Medicare Physician Fee Schedule Database:	
Emergency Update	27-28
Durable Medical Equipment, Prosthetics, Orthotics, &	
Supplies Fee Schedule: July 2007 Update	29-30
Medicare Physician Fee Schedule	
Database Update.....	31-33

Medicine

CPT Modifier 59: Proper Use	34-38
Physician Quality Reporting Initiative (PQRI) Coding &	
Reporting Principles	39-42
Frequently Asked Questions: Medical Review	43-45

Specialty Corner

Ambulance

Ambulance Transports: Medicare Payments	46-48
---	-------

Diagnostic Tests

Carrier Jurisdictional Pricing Rules: Purchased	
Diagnostic Services	49-50

Laboratory

CLIA Update.....	51-52
------------------	-------

Ophthalmology/Optometry

Ophthalmic Biometry: CPT Code 92136	
Coding Guidelines.....	53-54
CPT Modifiers 54 & 55.....	55

Podiatry

Podiatry Services: Medicare Overview	56-61
--	-------

Radiology

Bone Mass Measurements (BMMs)	62-66
Scope of Portable X-Ray Benefit:	
Manual Instruction	67

Etcetera

Medical Director’s Desk	68
Local Coverage Determination Updates.....	69
Medicare Opt Out HPSA/PSA Bonus Program Form ..	70
Redetermination Request Form	71
Reconsideration Request Form (Ohio)	72
Reconsideration Request Form (West Virginia)	73



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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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Patient Paid on Medicare Secondary Payer Claims

Effective for claims processed on and after July 2, 2007, Palmetto GBA will start processing the patient payment amount submitted in block 29 on all Medicare Secondary Payer claims. Currently Palmetto GBA does not process the patient payment amount submitted in block 29 of the CMS-1500 claim form when the amount is the same as the primary payer's payment on the Explanation of Benefits (EOB).

When submitting Medicare Secondary Payer (MSP) claims, you must only identify the patient payment amount in block 29 of the CMS-1500 claim form. The Internet Only Manual (Publication 100-4; Chapter 26; Section 10.4) states, "**Item 29** - Enter the total amount the **patient paid** on the covered services only". You must not identify the primary payer's payment in this block, or your claims may be processed in error.

Additional Information

You might want to review one of the following on the CMS Web site.

- CR 5488 at <http://cms.hhs.gov/transmittals/downloads/R1194CP.pdf>
- MM 5488 at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5488.pdf>
- SE 0716 at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0716.pdf>

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

New Deadline for Required Submission of the Form CMS-1500 (08-05)

Provider Types Affected

Physicians and suppliers who qualify for an exemption from the mandatory electronic claims submission requirements, and who submit Medicare claims to carriers, Medicare Administrative Contractors (MACs), and durable Medical Equipment Medicare Administrative Contractors (DME MACs) using the paper CMS-1500 claim form.

Provider Action Needed

CR 5616, from which this article is taken announces that, beginning July 2, 2007, you must use the CMS-1500 claim form, version (08-05) for paper claims submission to Medicare. Claims received on or after July 2, 2007, using CMS-1500 claim form, version (12-90) will be rejected.

Make sure that your billing staffs use CMS-1500 (08-05) claim form for your claims, beginning July 2, 2007.

Background

The CMS-1500 claim form is the paper form that physicians and suppliers, who qualify for an exemption from the mandatory electronic claims submission requirements (as set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32), use to submit claims.

CR 5568, released March 19, 2007, instructed Medicare contractors to continue to accept the earlier (12-90) version of CMS-1500 claim form (tentatively until June 1, 2007), because of reports that some vendors had printed the newer (08-05) version of the form incorrectly. After analysis, however, the problem does not appear to be as widespread as previously suspected.

Therefore, CR 5616, from which this article is taken, announces, based on the information at hand, that beginning July 2, 2007, you will need to submit claims using the CMS-1500 (08-05) claim form.

Note: CR 5616 addresses submission of the revised CMS-1500 paper claim form only, and has no bearing on the implementation of the National Provider Identifier (NPI), nor does CR 5616 mandate the submission of the NPI by July 1, 2007.

Additional Information

You can find more information about the official instruction issued to your Medicare contractor on this issue (CR 5616) at <http://www.cms.hhs.gov/Transmittals/downloads/R1247CP.pdf>.

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

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Unique Physician Identification Number (UPIN) Registry: Discontinued

Impact to You

This article is based on Change Request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

What You Need to Know

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice. Information on that contingency plan is at http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf.)

What You Need to Do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) Web site at <https://nppes.cms.hhs.gov/>. See the Background and Additional Information Sections of this article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007. See the note in the following box regarding the May 23, 2007, implementation by Medicare.

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Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated Web site at <http://www.cms.hhs.gov/NationalProvIdentStand/>. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007, or to disable the UPIN “look-up” functionality as of September 30, 2007.

The CMS will discontinue assigning on June 29, 2007, but CMS will maintain its UPIN public “look-up” functionality and Registry Web site (<http://www.upinregistry.com/>) through September 30, 2007.

Additional Information

For additional information regarding NPI requirements and use, please see MLN Matters articles, MM 4023 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf>) titled *Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms*, and MM 4293 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf>) titled *Revised CMS-1500 Claim Form*, which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR 5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R207PI.pdf>.

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

Medically Unlikely Edits (MUEs), Version 1.2, Effective July 1, 2007

Note: This article was revised on June 12, 2007, to reflect the changes made to CR 5603 on that date. The CR release date, transmittal number and Web address for accessing CR 5603 were changed. All other information remains the same.

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. Key points of CR 5603 are as follows:

- CR 5603 announces the upcoming release of the next version of the MUEs, which is version 1.2.
- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- CR 5603 states that Medicare carriers and A/B MACs will deny the entire claim line from providers with units of service that exceed MUE criteria and pay the other services on the claims, where the claims are processed by either Medicare's DME system (VMS) or carriers system (MCS).
- FIs and A/B MACs will return to providers (RTP) claims from institutional providers with units of service that exceed MUE criteria and which are processed by Medicare's fiscal intermediary shared system (FISS).
- With regard to MUEs, providers are reminded of the following:
 - An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
 - Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
 - 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 Advanced Beneficiary Notice (ABN).

Additional Information

To see the official instruction (CR 5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1265CP.pdf>.

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

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Correct Coding Initiative (CCI) Edits, Version 13.2, Effective July 1, 2007

Background

This article is based on Change Request (CR) 5604 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The latest package of CCI edits, Version 13.2, effective July 1, 2007, and the current Mutually Exclusive Code (MEC) edits will be available 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 (AMA'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 13.2, includes 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, and
- Mutually Exclusive Code (MEC) Edits.

Additional Information

The CCI and MEC file formats will be maintained in the Medicare Claims Processing Manual (Chapter 23, Section 20.9) which can be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

The official instruction, CR 5604, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1243CP.pdf>.

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

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Stage 3 National Provider Identifier (NPI) Changes: Transaction 835, and Standard Paper Remittance Advice (RA)

Impact to You

Be aware that Stage 3 of the NPI implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

What You Need to Know

Make sure you have your NPI, know how to use it, and are prepared to receive it back in your remittance advice processes.

What You Need to Do

Read the remainder of this article and be sure your staff are aware of how the NPI implementation impacts the remittance advice transactions you receive.

Background

This article discusses Stage 3 of Medicare’s fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs. Submitted NPIs will be crosswalked to the Medicare legacy number(s) for processing. Medicare’s internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

Scenario I	Single NPI	Cross walked to	Single Medicare legacy number
Scenario II	Multiple NPIs	Cross walked to	Single Medicare legacy number
Scenario III	Single NPI	Cross walked to	Multiple Medicare legacy numbers

CMS will adjudicate Medicare FFS claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The TIN will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of Taxpayer Identification Number (TIN) for tax purposes if the implementation guide allows it.

The Companion Documents and Flat Files for both Part A and B will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note that current requirements concerning the reporting of provider names and addresses still apply.

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Scenario I – Single NPI cross walked to single legacy number:

- **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (Employer Identification Number (EIN) Social Security Number (SSN) (EIN/SSN)) in the REF segment as Payee Additional ID. Medicare will report any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, there will be one remittance advice, and one check/Electronic Funds Transfer (EFT) per NPI.
- **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
- **MREP Software** - Medicare will show the Payee NPI at the header level and add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then, Medicare will add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

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Implementation

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

- For claims submitted to DMERcs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on October 2, 2007.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf>. The revised sections of Chapter 22-Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR 5452.

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

Stage 2 National Provider Identifier: Transaction 835, Standard Paper Remittance Advice, Medicare Claims Processing Manual, Chapter 22 Remittance Advice

Special note regarding remittance advice transactions: Just as it is important to understand when and where to report NPIs in claim transactions, it is crucial that providers understand and be ready to accept the provider identifiers as reported on remittance advice transactions. This article discusses what provider identifiers Medicare will report on remittances under Stage 2 of Medicare's NPI implementation. However, the processes will change as Medicare moves to Stage 3 implementation of the NPI. A key difference is that NPIs will be returned in many remittance transactions as the payee and the TIN as the additional payee identifier rather than the current practice of reporting TIN and legacy number respectively, even though the provider may have included the legacy number and the NPI on their claim. Providers need to review, and understand the impact of, Stage 3 on remittances as discussed in the *MLN Matters* article MM 5452, which is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

Also, note that this article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM 5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.

Background

This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs).

Medicare has published CR 4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

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The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006:** Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007:** Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward:** Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

Key Points

During Stage 2, if an NPI is received on the claim, it will be cross walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

Scenario I:	Single NPI	cross walked to	Single legacy number
Scenario II:	Multiple NPIs	cross walked to	Single Medicare legacy number
Scenario III:	Single NPI	cross walked to	Multiple Medicare legacy numbers

Note: The Standard Paper Remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level. CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy number but different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

Important Note: The following scenarios will change under Stage 3 of Medicare’s NPI implementation. To see the changes, see *MLN Matters* article MM 5452, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>.

Scenario I – Single NPI cross walked to single legacy number:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

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3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. SPR: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

Implementation

The implementation date for this instruction is October 2, 2006.

Additional Information

The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf>. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR 5081. The MLN Matters article that provides additional information about Stage 1 Use of NPI is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf>.

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

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Medigap (“Claim-Based”) Crossover Process to the Coordination of Benefits Contractor (COBC): Transition Process

Impact to You

This article is based on Change Request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap (“claim-based”) crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS’ Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate change request (CR 5662) that includes the Web site where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will also receive more detailed information regarding this change via their Medicare contractors’ provider newsletters/bulletins and Web sites.

What You Need to Know

October 1, 2007, is the effective date for completing the transition of the Medigap crossover process to the COBC. At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers. As CMS’ COBC assigns the new COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB Web site so that provider billing staffs may access it for purposes of including the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

What You Need to Do

During June through September 2007, CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

Background

Currently, in accordance with §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DMACs) transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed “Medigap claims-based crossover.” One of the “other” claims filing requirements for Medigap claim-based crossover is that the participating provider

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must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

Key Points of CR 5601

Be aware that during the transition period from June through September 2007, the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB Web site so that contractors **may direct providers to that link for purposes of obtaining regular updates.**

Effective with claims filed to Medicare on October 1, 2007:

- All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
- All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.
- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains "5" numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.
- Your Medicare contractor's screening process will also continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.

"Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer.**"

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In these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.

The Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):

“A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.”

REMEMBER: As CMS's COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format.**

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5601) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1242CP.pdf>.

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

Discarded Drugs and Biologicals: Single Use Vial/Package

What You Need to Know

CR 5520, from which this article is taken, revises the Medicare Claims Processing Manual, Chapter 17, Sections 40 and 100.2.9 to include language that references payment for administering (and discarding) both single use vials and single use packages. Specifically, the change is to clarify that Medicare will cover the amount of a single use vial or single use package of a drug or biological that was discarded along with the amount of that single use vial/package that was administered to the Medicare patient.

Background

CR 5520, from which this article is taken revises the *Medicare Claims Processing Manual*, Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) to ensure the proper billing of discarded drugs and biologicals in both single use vials and single use packages.

These revisions are summarized as follows:

- The Centers for Medicare and Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.
- Section 40 of Chapter 17 is amended to address single use vials/packages of drugs and biologicals. If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.
- Section 100.2.9 is amended to show that CMS will reimburse physicians, providers and suppliers for the amount of a drug or biological administered (and for the amount discarded) when:
 - The participating competitive acquisition program (CAP) physician has made a good faith effort to minimize the unused portion of the CAP drug or biological in scheduling patients and in ordering, accepting, storing, and using the drug or biological;
 - In its process of supplying the drug or biological to the participating CAP physician, the approved CAP vendor has made a good faith effort to minimize the unused portion of the drug or biological.

NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information

You can view CR 5520 at <http://www.cms.hhs.gov/Transmittals/downloads/R1248CP.pdf>. You will find the revised Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) as an attachment to that CR.

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

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Immune Globulin: Revised HCPCS Codes

Note: This article was corrected on June 20, 2007, to show the correct HCPCS code for Flebogamma Injection in Table 1 of page 2 is Q4091. All other information remains the same.

What You Need to Know

CR 5635, from which this article is taken, implements HCPCS coding changes for Immune Globulin. **On and after July 1, 2007:**

- **HCPCS code J1567** (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg)) **will no longer be payable by Medicare.**
- **In its place, the following HCPCS codes are payable: Q4087 (Octagam Injection), Q4088 (Gammagard Liquid Injection), Q4091 (Flebogamma Injection), and Q4092 (Gamunex Injection).**
- **In addition, for services on or after July 1, 2007, two new codes are payable:**
 - **HCPCS code Q4089 (Rhopylac injection).** *Note that currently, Rhophylac® is the only product that should be submitted using HCPCS code Q4089. If other products under the Food and Drug Administration's (FDA) approval for Rhophylac® become available, HCPCS code Q4089 would be used to submit for such products.*
 - **HCPCS code Q4090 (HepaGam B injection).** *Note that currently, HepaGam BTM, when given intramuscularly, is the only product that should be submitted using HCPCS code Q4090. If other products under the FDA's approval for HepaGam BTM IM become available, HCPCS code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be submitted using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.*
- For institutional claims, revenue code 0636 should be used for submitting HCPCS codes Q4087, Q4088, Q4089, Q4090, Q4091, and Q4092.
- As described in CR 5428, Medicare contractors will pay for pre-administration-related services (HCPCS code G0332) associated with intravenous Immune Globulin administration when HCPCS codes Q4087, Q4088, Q4091, or Q4092 is billed in lieu of HCPCS code J1567.

Make sure that your billing staffs are aware of these Immune Globulin HCPCS code changes.

Background

CR 5635, from which this article is taken, implements HCPCS Coding Changes for Immune Globulin, Effective for services on or after July 1, 2007. See Table 1, below, for details.

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**Table 1
HCPCS Code Changes for Immune Globulin
Effective July 1, 2007**

HCPCS Code	Short Description	Long Description
Status: Not Payable by Medicare on or after July 1, 2007		
J1567	Immune globulin, liquid	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg
Status: Payable for services on or after July 1, 2007		
Q4087	Octagam Injection	Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4088	Gammagard Liquid Injection	Injection, immune globulin (Gammagard Liquid), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4091	Flebogamma Injection	Injection, immune globulin (Flebogamma), intravenous, non-lyophilized(e.g. liquid), 500 mg
Q4092	Gamunex Injection	Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg
Status: New/Payable for services on or after July 1, 2007		
Q4089*	Rhophylac injection	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090^	HepaGam B injection	Injection, hepatitis B immune globulin (HepaGam B), intramuscular, 0.5 ml

*Currently, Rhophylac® is the only product that should be billed using HCPCS code Q4089. If other products under the FDA approval for Rhophylac® become available, HCPCS code Q4089 would be used to bill for such products.

^Currently, HepaGam BTM, when given intramuscularly, is the only product that should be billed using HCPCS code Q4090. If other products under the FDA's approval for HepaGam BTM IM become available, HCPCS code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.

Additional Information

You can find the official instruction issued to your Medicare contractor about the revised HCPCS codes relating to Immune Globulin by going to CR 5635, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1261CP.pdf>.

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Payment limits for the new Q HCPCS codes will be included in the July 2007 quarterly Average Sales Price payment file, which will be posted at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a2007aspfiles.asp#TopOfPage>.

In addition, more information regarding the Outpatient Prospective Payment System (OPPS) and the new Q HCPCS codes in the July update of OPPS Addendum A and Addendum B on the hospital outpatient Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>.

You might also want to look at CR 5428 (Medicare Payment for Pre-administration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007). The *MLN Matters* article (MM5428) associated with that CR is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5428.pdf>.

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

HCPCS Codes for Albuterol, Levalbuterol, and Reclast®: July 2007 Update

What Providers Need to Know

CR 5645, from which this article is taken, implements the July 2007 quarterly update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®.

Effective for dates of service on or after July 1, 2007, the following HCPCS codes are **no longer payable by Medicare**: J7611, J7612, J7613, and J7614; and the following HCPCS codes **are payable by Medicare**: Q4093, Q4094, and Q4095. HCPCS code J3487 should continue to be used for Zometa®.

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

Background

CR 5645, from which this article is taken, implements the July 2007 quarterly update to the HCPCS codes for Albuterol, Levalbuterol, and Reclast®.

Effective July 1, 2007, the HCPCS codes in **table 1** will no longer be payable for Medicare.

HCPCS Codes Not Payable for Dates of Service on or after July 1, 2007: Table 1

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol non-comp con	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol non-comp unit	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol non-comp unit	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

In place of the Table 1 codes, the HCPCS codes displayed in **Table 2** will be payable, effective July 1, 2007.

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HCPCS Codes Payable for Services on or After July 1, 2007: Table 2

HCPCS Code	Short Description	Long Description
Q4093	Albuterol inh non-comp con	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)
Q4094	Albuterol inh non-comp u d	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)

In addition, a new HCPCS code, Q4095 (in **Table 3**) will be effective July 1, 2007, for Reclast®.

HCPCS Q4095 Payable for Services on or after July 1, 2007: Table 3

HCPCS Code	Short Description	Long Description
Q4095	Reclast injection	Injection, zoledronic acid (Reclast), 1 mg

Also, please note the following:

Currently, Reclast® 5 mg/100 ml bottle (NDC 0078-0435-61) is the only product that should be billed using HCPCS code Q4095. If other products under the FDA's approval for Reclast® become available, HCPCS code Q4095 would be used to bill for such products.

HCPCS code J3487 (short description: Zoledronic acid; long description: Injection, zoledronic acid, 1 mg) is used to bill for products under the FDA's approval for Zometa® or such therapeutically equivalent products that may become available as identified in the FDA's Orange Book.

Payment limits for the new Q HCPCS codes will be included in the July 2007 quarterly Average Sales Price payment file, when those files are posted at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage

Payment information for the new Q HCPCS codes under the Hospital Outpatient Prospective Payment System (OPPS) can be found in the July 2007 update of OPPS Addendum A and Addendum B when those addendums are added to the hospital outpatient Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage/>.

Additional Information

You can find the official instruction, CR 5645, issued to your carrier, FI (including RHHI), A/B MAC or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1260CP.pdf>.

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

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EDI Migration to the GPNet Front End

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

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

Advantages of using GPNet are:

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

Important information to know about GPNet submissions is:

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

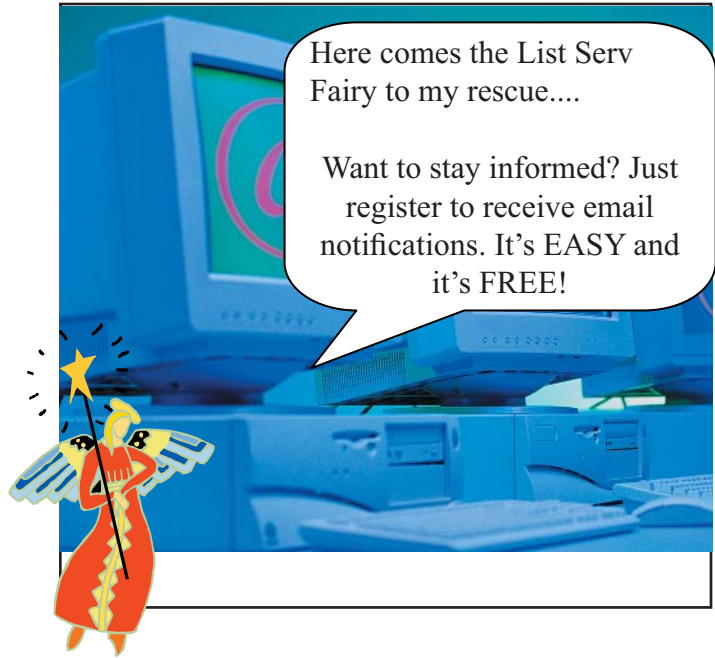
If you have questions regarding your transition to the GPNet front end, please contact our Technical Support Center toll-free at 1-866-308-5438.

Palmetto Place

Dr. Hava Question



Oh no! I don't know how to submit these claims to Medicare. How will I ever find out the information I need to keep cash flowing into the office?



Wow! I'm not having any trouble submitting my claims and getting paid. The email notifications from Palmetto GBA are fantastic and they make it easy for me to stay up-to-date about the changes to the Medicare Part B Program.

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

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Free Evaluation & Management Medicare Part B Seminars

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

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

Ohio Seminars

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

West Virginia Seminars

Date	Location	Time
Wednesday, August 29, 2007	Clarion Hotel & Conference Center 233 Lowe Drive Shepherdstown, WV 25443	9:00 a.m. – 12:00 p.m..

Registration:

To Register for a seminar go to:

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

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

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

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

Note: This article was revised on January 12, 2007, to reflect that CR 5459 was revised by CMS. The article was revised to reflect the new CR release date, transmittal number, and the Web address for accessing CR 5459. All other information remains the same.

Background

This article and related Change Request (CR) 5459 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS Final Rule. CR 5459 amends those payment files.

Key Points

You may wish to **review Attachment 1** of the CR 5459, which is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1143CP.pdf>. The following key points summarize the specifics that are identified in the attachment to CR 5459.

- The physician fee schedule status indicators for oncology demonstration HCPCS codes G9050 to G9062 for 2007 are “**I**”; these **codes are invalid** for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the Oncology Demonstration, see the *MLN Matters* article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf>.)
- Oncology **demonstration HCPCS codes** G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006 in 2007**.
- Active Oncology demonstration codes in the range HCPCS codes G9063 to G9139 have status indicators of “**M**” on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II CPT codes 3047F and 3076F and Category III CPT code 0152T have been deleted for 2007.
- G HCPCS codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- Q HCPCS codes Q4083, Q4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted to the CMS Web site.
- Incorrect Diagnostic Supervision Indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected Multiple Procedure Codes of 0 and Diagnostic Family Imaging Indicators of 99 have been assigned to HCPCS codes/modifier G0389, G0389-TC, CPT codes/HCPCS modifier 70554, 70554-TC, 70555, 70555-TC, 76776, and 76776-TC.
- As identified in the attachment to CR 5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for CPT codes 44180, 44186, 73223, 73223-26 (CPT modifier),

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76775, 76775-TC (HCPCS modifier), 76775-26 (CPT modifier), 93503, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 95060, 95065, HCPCS codes/modifiers G0389, G0389-TC, and HCPCS code/CPT modifier G0389-26.

- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, HCPCS code G0377 (Administration of vaccine for Part D drug) is added to the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to CPT code 90471 (just as payment is made for HCPCS codes G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating Prescription Drug Plan. Medicare will not pay for the vaccine itself.
- Effective January 1, 2007, the following G HCPCS codes are added to the MPFSDB with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G8358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q HCPCS codes are in effect for these products as of January 1, 2007, i.e., Q4083 (Hyalgan/supartz inj per dose), Q4084 (Synvisc inj per dose), Q4085 (Euflexxa inj per dose), and Q4086 (Orthovisc inj per dose).
- Procedure status I is assigned to HCPCS code J7319, effective January 1, 2007.
- Effective January 1, 2007, the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.
- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These CPT codes are 38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, and 38215. The RVUs are listed for these codes in the attachment to CR 5459.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5459) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf>.

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

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

Note: This article was revised on June 19, 2007, to clarify that the modifier that should not be used with HCPCS codes E0691, E0692, E0693, and E0694 for dates of service on or after January 1, 2005, is the KF HCPCS modifier. All other information remains the same.

Provider Action Needed

This article is based on Change Request (CR) 5641, which provides the July 2007 quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error or that may no longer be paid under the fee schedule. Be sure billing staff are aware of these changes.

Background

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

CR 5641 provides specific instructions regarding the July quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

Key Points

The following are key changes in the July 2007 quarterly update of the DMEPOS fee schedule including the Healthcare Common Procedure Coding System (HCPCS) codes:

- **HCPCS code E0762** (Transcutaneous electrical joint stimulation device system, includes all accessories) is:
 - **Added** to the fee schedule on **July 1, 2007, and**
 - **Effective** for claims submitted with dates of service on or after **January 1, 2007.**
- HCPCS codes added July 1, 2007 with dates of service on or after July 1, 2007 are:
 - **K0553** Combination Oral/Nasal Mask, Used With Continuous Positive Airway Pressure Device, Each
 - **K0554** Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each

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- **K0555** Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair
- Suppliers must use the “**KL**” **HCPCS modifier** on claims for all diabetic supplies that are **delivered via mail** with dates of service on or after **July 1, 2007**, with the following HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259. The KL HCPCS modifier must be used with diabetic supplies that are ordered remotely (i.e., by phone, email, internet, or mail) and delivered to the beneficiary’s residence by common carriers (e.g., U.S. postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier storefronts.
- Fee schedule amounts for HCPCS code E2374 (Power Wheelchair Accessory, Hand or Chin Control Interface, Standard Remote Joystick (Not Including Controller), Proportional, Including all Related Electronics and Fixed Mounting Hardware, Replacement Only) are being revised to correct errors in the fee schedule calculation. Medicare contractors will adjust previously processed claims with dates of service on or after January 1, 2007, if resubmitted as adjustments.
- If suppliers re-submit previously processed claims for **HCPCS code K0864 in Puerto Rico with dates of service from November 15, 2006 through March 31, 2007**, the DME MACs and DMERCs will adjust the claims for payment.

Also, after consulting with the Food and Drug Administration, the Centers for Medicare & Medicaid Services (CMS) determined that **ultraviolet light therapy** systems are classified as **class II devices** and are not class III devices. Thus, suppliers **should not submit the class III “KF” HCPCS modifier with claims for HCPCS codes E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2005**. CMS is removing HCPCS codes E0691, E0692, E0693, and E0694, billed with the KF HCPCS modifier, from the fee schedule, effective July 1, 2007 and as of that date, Medicare contractors will reject claims for HCPCS codes E0691, E0692, E0693, and E0694, which contain the KF HCPCS modifier and a date of service on or after January 1, 2005. Medicare contractors will adjust previously processed claims for HCPCS codes E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2007, if suppliers resubmit the claims as adjustments.

The HCPCS Quarterly Update public use file, containing the long and short descriptors for all new codes, is available for downloading at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp .

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5641) at <http://www.cms.hhs.gov/Transmittals/downloads/R1263CP.pdf>.

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

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Medicare Physician Fee Schedule Database (MPFSDB) 2007 Update

Impact to You

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

What You Need to Know

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

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

What You Need to Do

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

Background

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

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

- Several changes retroactive to January 1, 2007. The changes are for the following:
 - CPT codes:
 - 00797 (base units set to 11);
 - 0115T, 0116T, and 0117T (procedure status is now N);
 - 19301 (short descriptor is Partial mastectomy);
 - 33208 (work RVUs set to 8.72);
 - 75365 with HCPCS modifier TC (diagnostic indicator set to 02); and
 - 77422, 77423 (PE RVU changes).
 - HCPCS codes:
 - G9041, G9042, G9043, G9044 (PE RVU changes).

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- CPT codes 0024T and 0133T are assigned a procedure status of I effective for dates of service on or after July 1, 2007.
- As previously mentioned, CPT modifier 8P is added for the PQRI program.
- The list of G HCPCS codes that are no longer used for the PQRI program as of July 1, 2007.
- The list of new CPT Category II codes, new G HCPCS codes and the new/revised descriptors for the codes that will be used for the PQRI, effective for dates of service on or after July 1, 2007.
- Information on Category III CPT codes (0178T through 0180T (all of which deal with electrocardiograms), 0181T (corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report), and 0182T (High dose rate_electronic brachytherapy, per fraction), which are effective for dates of service on or after July 1, 2007.
- Effective July 1, 2007, HCPCS codes J1567, J7611, J7612, J7613, and J7614 will be assigned a procedure status of I.
- Information related to HCPCS codes Q4087 through Q4095, which are added to the MPFSDB as of July 1, 2007 with a status indicator of E.

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

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

The following are revisions to the current MPFSDB:

HCPCS Code	State	NON-FACILITY SETTING			FACILITY SETTING		
		PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
G9041	OH	\$25.79	\$24.50	\$28.18	\$25.79	\$24.50	\$28.18
	WV	\$24.75	\$23.51	\$27.04	\$24.75	\$23.51	\$27.04
G9042	OH	\$14.04	\$13.34	\$15.34	\$14.04	\$13.34	\$15.34
	WV	\$13.00	\$12.35	\$14.20	\$13.00	\$12.35	\$14.20
G9043	OH	\$14.04	\$13.34	\$15.34	\$14.04	\$13.34	\$15.34
	WV	\$13.00	\$12.35	\$14.20	\$13.00	\$12.35	\$14.20
G9044	OH	\$11.92	\$11.32	\$13.02	\$11.92	\$11.32	\$13.02
	WV	\$11.14	\$10.58	\$12.17	\$11.14	\$10.58	\$12.17

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

(State = Ohio (OH) and West Virginia (WV), PAR = Participating (Non-Facility Setting) fee schedule amount, NON PAR = Nonparticipating (Non-Facility Setting) fee schedule amount, LMT CHG = Limiting charge applies to the Nonparticipating (Non-Facility Setting) fee schedule amount, #F PAR = Facility Setting Participating fee schedule amount, #F NON PAR = Facility Setting Nonparticipating fee schedule amount, #F LMT CHG = Limiting charge applies to Facility Setting Nonparticipating fee schedule amount. Limiting charge applies to unassigned claims by a nonparticipating provider in or out of a facility setting).

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5614) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf>.

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

CPT Modifier 59: Proper Use

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of CPT modifier “-59”. The article only clarifies existing policy.

Background

Under certain circumstances, a physician may need to indicate that a procedure or service was distinct or independent from other services, and CPT modifier “-59” may be appropriate depending on the circumstances. CPT modifier “-59” is used to identify procedures/services that are not normally reported together, and this includes the following procedures/services that are not ordinarily encountered or performed on the same day by the same physician:

- A different
 - Session or patient encounter,
 - Procedure or surgery,
 - Site or organ system, or
- A separate
 - Incision/excision,
 - Lesion, or
 - Injury (or area of injury in extensive injuries)

When another already established modifier is appropriate, it should be used rather than CPT modifier “-59”. CPT modifier “-59” is an important National Correct Coding Initiative (NCCI) associated modifier that is often used incorrectly, and it should only be used if no more descriptive modifier is available or when its use best explains the circumstances.

For the NCCI, the primary purpose of CPT modifier “-59” is to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes.

NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances.

If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at:

- Different anatomic sites, or
- Different patient encounters.

Medicare carrier and MAC Part B claim processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit.

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CPT modifier “-59” and other NCCI-associated modifiers **should NOT be used** to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

One of the misuses of CPT modifier “-59” is related to the portion of the definition of CPT modifier “-59” allowing its use to describe “different procedure or surgery.” The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The related NCCI edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. **The provider cannot use CPT modifier “-59” for such an edit based on the two codes being different procedures/surgeries.** However, if the **two procedures/surgeries are performed at separate anatomic sites** or at **separate patient encounters on the same date of service**, CPT modifier “-59” may be appended to indicate that they are different procedures/surgeries on that date of service.

Use of CPT modifier “-59” to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of CPT modifier “-59”. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, **it does not include treatment of contiguous structures of the same organ.** For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitutes a single anatomic site.

Examples of CPT Modifier “-59” Usage

Following are some examples developed to help guide physicians and providers on the proper use of CPT modifier “-59”:

Example 1: Column 1 Code/Column 2 CPT code 11055/11720

- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

Policy: Mutually exclusive procedures CPT Modifier “-59” is:

- Only appropriate if procedures are performed for lesions anatomically separate from one another or if procedures are performed at separate patient encounters.
- Don’t report CPT codes 11055-11057 for removal of hyperkeratotic skin adjacent to nails needing debridement.

Example 2: Column 1 Code/Column 2 CPT Code 11719/11720

- CPT Code 11719 – Trimming of nondystrophic nails, any number
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

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Policy: Mutually exclusive procedures

CPT modifier “-59” is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters

Example 3: Column 1 Code/Column 2 CPT Code 17000/11100

- CPT Code 17000 – Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
- CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Policy: HCPCS/CPT coding manual instruction/guideline

CPT modifier “-59” is only appropriate if procedures are performed on separate lesions or at separate patient encounters.

Example 4: Column 1 Code/Column 2 CPT Code 38221/38220

- CPT code 38221 - Bone marrow; biopsy, needle or trocar
- CPT code 38220 - Bone marrow; aspiration only

Policy: Standards of medical/surgical practice

Use of CPT modifier “-59” should be uncommon but appropriate for these circumstances:

- Different sites - contralateral iliac crests; iliac crest and sternum;
- Different incisions - same iliac crest; or
- Different encounters.

Example 5: Column 1 Code/Column 2 CPT Code 45385/45380

- CPT Code 45385 - Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- CPT Code 45380 - Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Policy: More extensive procedure

CPT modifier “-59” is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

Example 6: Column 1 Code/Column 2 CPT Code 47370/76942

- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Policy: HCPCS/CPT coding manual instruction/guideline

CPT modifier “-59” is only appropriate if the ultrasonic guidance service (CPT code 76942) is performed for a procedure done unrelated to the surgical laparoscopic ablation procedure.

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Example 7: Column 1 Code/Column 2 CPT Code 93015/93040

- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Policy: More extensive procedure

CPT modifier “-59” is only appropriate if the rhythm ECG service (CPT code 93040) is performed unrelated to the cardiovascular stress test procedure at a different patient encounter.

Example 8: Column 1 Code/Column 2 CPT Code 93529/76000

- CPT Code 93529 – Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
- CPT Code 76000 – Fluoroscopy (separate procedure), up to 1 hour physician time, other than CPT codes 71023 or 71034 (e.g., cardiac fluoroscopy)

Policy: Standards of medical/surgical practice

CPT modifier “-59” is only appropriate if the fluoroscopy service (CPT code 76000) is performed for a procedure done unrelated to the cardiac catheterization procedure.

Example 9: Column 1 Code/Column 2 CPT Code 95903/95900

- CPT Code 95903 – Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
- CPT Code 95900 - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Policy: More extensive procedure

CPT modifier “-59” is only appropriate if the two procedures are actually performed on different nerves or in separate patient encounters.

Example 10: Column 1 Code/Column 2 CPT Code 97140/97530

- CPT Code 97140 – Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Policy: Mutually exclusive procedures

CPT modifier “-59” is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. **The two codes cannot be reported together if performed during the same 15 minute time interval.**

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Example 11: Column 1 Code/Column 2 CPT Code 98942/97112

- CPT Code 98942 – Chiropractic manipulative treatment (CMT); spinal, five regions
- CPT Code 97112 – Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Policy: Standards of medical/surgical practice

CPT modifier “-59” is only appropriate if the physical therapy service (CPT code 97112) is performed in a different region than the CMT and the provider is eligible to report physical therapy codes under the Medicare program.

Additional Information

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

Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles

What Providers Need to Know

CR 5640, from which this article is taken, provides information about, and instructions for, the coding and reporting of, quality measures in the CMS PQRI. The current PQRI reporting period is for claims with dates of service from July 1, 2007, through December 31, 2007. **Prompt submission of claims with quality measures is imperative as the claims will only be included in the PQRI analysis (and the associated bonus payment calculation) if received by Medicare's National Claims History (NCH) file on or before February 29, 2008.**

Background

CMS (authorized under Title 1, Section 101 of the 2006 Tax Relief and Health Care Act of 2006 (TRHCA)), created the 2007 Physician Quality Reporting Initiative (PQRI), which establishes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5% of total allowed charges for covered Medicare physician fee schedule services during that same period.

2007 Physician Quality Reporting Initiative Specifications

In 2007, PQRI reporting is based on 74 unique measures. The *CMS 2007 Physician Quality Reporting Initiative Specifications* document (referred to in this article and in related CR 5640 as *Specifications*) contains the 74 measures associated with clinical conditions that are routinely represented on Medicare fee-for-service claims through the use of diagnosis codes from the *International Classification of Diseases, 9th Revision-Clinical Modification* (ICD-9-CM) and procedure codes from the *HealthCare Common Procedure Coding System* (HCPCS). You can find this *Specifications* document on the CMS PQRI Web site (<http://www.cms.hhs.gov/pqri>).

The *Specifications* describe specific measures and associated codes that address various aspects of care such as: prevention, management of chronic conditions, management of acute episodes of care, procedure-related care, resource utilization, and care coordination. They also contain descriptions for each PQRI quality measure and include instructions on how to code each measure's numerator and denominator.

Each measure has a **reporting frequency** requirement for each eligible patient seen during the reporting period, (for example, report one-time only, once for each procedure performed, once for each acute episode, per each eligible patient). Some measures also include specific **performance timeframes** related to the clinical action in the numerator that may be distinct from the measure's reporting frequency requirement. (For example, performance timeframes may be stated as "within 12 months" or "most recent.")

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PQRI Quality-Data Codes

There are specific PQRI quality-data codes associated with each of the 2007 PQRI measures. These quality-data codes, translate clinical actions so they can be captured in the administrative claims process, are primarily CPT II codes, although temporary G HCPCS codes will be used on an exception basis where CPT Category II codes have not yet been developed.

PQRI quality-data codes can relay information such as:

- The measure requirement was met;
- The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers); and
- The measure requirement was not met and the reason is not documented in the medical record (i.e., using the 8P reporting modifier).

You should be aware that individual PQRI quality-data codes can be associated with more than one measure. In order to determine which quality-data codes and modifiers to report as a line item on a claim, you will need to understand the measures that you have selected to report.

Further, PQRI measures may require that you append a modifier to a CPT Category II code. CPT Category II modifiers serve to exclude patients from a given measure's denominator when the measure's specification permits their use, and may only be reported with CPT II codes. They cannot be used with G HCPCS codes. Coding instructions included in the *Specifications* document indicate when a modifier is required.

There are two kinds of CPT II Modifiers:

- **Performance Measure Exclusion Modifiers** indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. Performance measure exclusion modifiers fall into one of three categories:
 - **1P -- Performance Measure Exclusion Modifier due to Medical Reasons:** Includes: Not Indicated (absence of organ/limb, already received/performed, other); Contraindicated (patient allergic history, potential adverse drug interaction, other)
 - **2P - Performance Measure Exclusion Modifier due to Patient Reasons:** Includes: Patient declined; economic, social, or religious reasons; other patient reasons
 - **3P - Performance Measure Exclusion Modifier due to System Reasons:** Includes: Resources to perform the services not available; insurance coverage/payor-related limitations; other reasons attributable to health care delivery system
- **Performance Measure Reporting Modifier** facilitates reporting a case when the patient is eligible but an action described in a measure is not performed and the reason is not specified or documented.
 - **8P - Performance Measure Reporting Modifier - action not performed, reason not otherwise specified**

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Submission of Quality-Data Codes

2007 PQRI requires that the PQRI quality-data codes be added as a line item on the claim submitted to carriers/MACs for the associated covered service. Claims with quality-data code line items can be submitted on the electronic 837-P, or as a paper claim if you are authorized to submit paper claims.

Key claim submission information is listed below:

- The “submitted charge” field for the **quality-data code line item** cannot be left blank or the claim will be rejected;
- Carriers/MACs *will not* pass Quality-data codes on **rejected claims** to the National Claims History (NCH) File. You will need to re-submit rejected claims with all of the corrections that the carrier/MAC require, including all quality-data code line items;
- Quality-data code line items must be submitted with a **charge of zero dollars** (\$0.00). If your system does not allow a \$0.00 line item charge, use a small amount such as \$0.01. (Carriers/MACs will deny quality-data code line items for payment when submitted with a charge of zero dollars or a small amount (e.g., \$0.01), but will pass these codes through to the **NCH file** to be processed for PQRI analysis.)
- The CPT Category II code, which supplies the numerator, must be reported on the same claim form as the payment ICD-9 and CPT Category I codes, which supply the measure’s denominator.
 - *Multiple CPT Category II codes can be reported on the same claim, as long as the corresponding denominator codes are also included as line items for that claim.*
 - *Multiple Eligible Professionals (using their National Provider Identifiers (NPIs)) may be reported on the same claim with each quality data code line item corresponding to the services rendered by that professional for that encounter.*
 - *Medicare’s claims processing systems will treat previously submitted claims, that are resubmitted only to add PQRI quality-data codes, as duplicate claims. These claims will not be included in the PQRI analysis.*

National Provider Identifier (NPI) Requirement for Participation in 2007 PQRI

To participate in PQRI, you must have an NPI, which you will need to provide in the “Rendering Provider” field on the claim. For claims submitted by group practices, multiple individual eligible professionals can report quality-data codes on the same claim, with each individual’s NPI listed in the “Rendering Provider” field for the quality-data code line item. To learn more about the NPI and how to obtain one, visit the NPI Web site at http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp .

Timeliness of Claim Submission

Quality-data codes must be reported on claims for payment of services provided during the reporting period which is for dates of service on and after July 1, 2007, through December 31, 2007. It is important to note that **all** claims must reach the NCH file by February 29, 2008, to be included in the bonus calculation. Therefore, you should promptly file claims for services furnished toward the end of the reporting period.

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PQRI Analysis

Analysis of PQRI claims will not be conducted by the carrier or the MAC. Rather, CMS will use an independent PQRI analysis contractor to analyze data from NCH and to evaluate PQRI data submitted on claims to determine eligibility for a bonus and to calculate the bonus amount.

2007 PQRI Participation Handbook

CMS will issue a detailed handbook about how to implement PQRI measures in clinical practice, and facilitate successful reporting. The handbook will include information, arranged in alphabetical order by clinical condition, to help you:

- Identify eligible cases based on ICD-9-CM and CPT Category I codes;
- Choose the correct quality-data codes to report;
- Know when to use “exclusion” CPT modifiers (i.e., 1P, 2P, and 3P); and
- Know when to use a reporting CPT modifier (i.e., 8P).

The handbook will also include sample clinical vignettes that will describe how to code and report a particular measure under unique circumstances that may arise.

Additional Information

You can find the official instruction, CR 5640, at <http://www.cms.hhs.gov/Transmittals/downloads/R277OTN.pdf>. Also, you may wish to review *MLN Matters* article, MM 5558, for additional information. That article provides an overview of the 2007 PQRI and identifies who is eligible to participate. The article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5558.pdf>.

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

Frequently Asked Questions: Medical Review

Can we consider both body areas and organ systems together if we are using the 1995 E/M guidelines for the Examination Component?

Answer: No, for the exam component, you may either use body areas or organ systems, not a combination.

Resources:

- Palmetto GBA *Physician/Supplier Guide*: <http://www.PalmettoGBA.com/boh/guide> or <http://www.PalmettoGBA.com/bwv/guide>
- CMS E/M Documentation Guidelines: http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

A Nephrologist's patient is admitted to the hospital. The admitting physician then requests a consult by the nephrologist because the patient has a new problem. Can the nephrologist submit a consult for this patient?

Answer: A consultation may only be submitted if all three of the requirements for a consultation are met. There must be a request for an opinion, a rendering of an opinion to the requesting physician, and a written report of his/her findings must be provided to the requesting physician. If these requirements are not met, then the nephrologist should submit the subsequent hospital visit care code because there is a transfer of care for the established condition. If the request is for an opinion regarding a *new* problem, and the 3 R's (**Request, Render, and Report**) are met, a consultation CPT code may be submitted.

Carriers pay for a reasonable and medically necessary consultation service when all of the following criteria for the use of a consultation code are met:

- Specifically, a consultation service is distinguished from other evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPP's in the State in which he/she practices. Applicable collaboration and general supervision rules apply as well as billing rules:
- A request for a consultation from an appropriate source and the need for consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and
- After the consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

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The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge. Consultations may be submitted based on time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician or qualified NPP and the patient. The preceding requirements (request, evaluation {or counseling/coordination} and written report) shall also be met when the consultation is based on time for counseling/coordination.

Resources:

- Internet-Only Manual: Publication 100-04, Chapter 12: Physicians/Nonphysician Practitioners section 30.6.10 <http://www.cms.hhs.gov/manuals>

What is the difference between the 1995 and 1997 Evaluation & Management (E/M) Guidelines?

Answer: In comparing the guidelines, the differences are as follows:

1995 vs. 1997 Differences

E/M Components		1995	1997
History	History of the Present Illness (HPI)	Description of the Elements (e.g., location, quality, severity)	Descriptions of the Elements (i.e. location, quality, severity..) or Status of 3 Chronic/Inactive Diseases
	Review of Systems	No difference	No difference
	Past, Family, and Social (PFSH)	No difference	No difference
Examination		Body Areas or Body Systems	General Multi-System or Single Organ System (e.g., Cardiovascular, Eyes, Psychiatric)
Decision Making		No difference	No difference

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You may follow either the 1995 or 1997 guidelines in determining the appropriate level of service.

Resources:

- Palmetto GBA *Physician/Supplier Guide*: <http://www.PalmettoGBA.com/boh/guide> or <http://www.PalmettoGBA.com/bwv/guide>
- CMS E/M Documentation Guidelines: http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

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Ambulance Transports: Medicare Payments

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

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

1. Would the patient’s health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.
2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient’s illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

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

- a) Basic life support
- b) Advanced life support

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- c) Specialty care transport
- d) Air transport - fixed wing and rotary wing

Emergency Ambulance Transport

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

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

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

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

Non-Emergency Ambulance Transports

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

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

Documentation Requirements

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

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

How to Avoid Improper Billing

Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5442 "Ambulance Fee Schedule – Medical Conditions List – Manualization," which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.

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

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

Additional Information

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

CR 5442, dated February 23, 2007, "Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions," is located at <http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf>.

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

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Carrier Jurisdictional Pricing Rules: Purchased Diagnostic Services

Note: This article was revised on June 13, 2007, to delete an unnecessary note from page 2 regarding current processes and to add a bullet point (in italics) on page 3. All other information remains the same.

Provider Action Needed

CR 5543, from which this article is taken, replaces the temporary physician billing instructions specified in CR 3630 (issued on December 23, 2004) with new billing procedures that (effective October 1, 2007) allow all physicians and suppliers to receive the correct payment amount for all purchased diagnostic services, including those performed outside of their local carrier's/Medicare Administrative Contractor's (MAC) jurisdiction.

Background

Through CR 3481, the Centers for Medicare and Medicaid Services (CMS), on April 1, 2005, implemented a Medicare Physician Fee Schedule (MPFS) national abstract file containing the Healthcare Common Procedural Coding System (HCPCS) codes, billable as a purchased diagnostic test/interpretation, for every locality throughout the country. With this file's implementation, CMS changed the carrier jurisdictional pricing rules for purchased diagnostic tests/interpretations to allow suppliers (including laboratories, physicians, and independent diagnostic testing facilities) to bill their local carrier/MAC for these services and receive the correct payment amount, regardless of the location where the service was performed. (See CR 3481, issued on October 29, 2004.)

Note: Carrier jurisdictional pricing rules for all other services payable under the MPFS have remained in effect.

However, CMS delayed implementation of the CR 3481's billing instructions for physicians, because of a previously noted potential problem with reporting the locality data in physician claims for such services performed outside of the local carrier's jurisdiction. Rather, through CR 3630, CMS implemented a temporary change in the carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians providing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services and receive the local rate.

CR 5543, from which this article is taken, replaces the temporary physician billing instructions specified in CR 3630 with new billing procedures to allow all physicians and suppliers to receive the correct payment amount for all purchased diagnostic services (based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules), including those performed outside of the local carrier's jurisdiction, effective for claims with dates of service on or after October 1, 2007.

CR 5543's key points include:

- Effective for claims with dates of service on or after October 1, 2007, carriers/MACS will use the MPFS national abstract file for purchased diagnostic tests/interpretations to price all claims for purchased

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diagnostic services based on the ZIP code of the location where the service was rendered, including those submitted by physicians for purchased diagnostic services performed outside of the local carrier's jurisdiction, in accordance with the carrier jurisdictional pricing rules specified in Chapter 1, Section 10.1.1 of the Medicare Claims Processing Manual.

- Physicians and suppliers must begin reporting the rendering physician's/supplier's information and the location where the service was rendered on all claims for purchased tests/interpretations with dates of services on or after October 1, 2007, including those for tests/interpretations performed outside of the local carrier's jurisdiction, following the instructions for submitting a purchased diagnostic service claim in Chapter 1, Sections 10.1.1.2 and 30.2.9 of the Medicare Claims Processing Manual.
- Physicians/suppliers are not to report the NPI (or provider identification number (PIN)) of the out-of-jurisdiction performing physician/supplier when submitting a claim for a diagnostic service purchased outside of their local carrier's/MAC's jurisdiction.
- Physicians and suppliers are reminded they may only submit claims for purchased tests/interpretations when these services are performed within the United States. (In this context, the term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. See Chapter 1, Section 10.1.4 of the Medicare Claims Processing Manual for additional information.)

Additional Information

You can find the official instruction, CR 5543, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1250CP.pdf>.

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

CLIA Update

Listed below are the latest tests approved by the Food and Drug Administration as waived under CLIA effective July 2, 2007.

CPT Code/HCPCS Modifier & Test Name	Manufacturer	Use
80101 QW Redwood Toxicology Laboratory Reditest 6 Cassette substance abuse screening device (Professional Use)	Innovacon	Screening test for the presence or detection of amphetamines, cannabinoids (THC), cocaine metabolites, methamphetamines, opiates, and phencyclidine in urine.
80101 QW Drug Detection Devices Ltd. Multi-Drug Multi-Line Screeners Dip Drug Test with the Integrated Screeners AutoSplit KO Test Cup	Innovacon	Screening test for the presence or detection of amphetamines, cannabinoids (THC), cocaine metabolites, methamphetamines, meth- ylenedioxymethamphetamine, opiates, and phencyclidine in urine.
80101 QW Innovacon Integrated E-Z Split Key Cup II (Professional Use)	Innovacon	Same
80101 QW Wolfe Drug Testing RealityCheck Integrated Specimen Cup	Innovacon	Same
82274 QW & G0328 QW InSure Quik Fecal Immunochemical Test (F.I.T.)	Enterix, Inc.	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening) by immunoassay.
82947 QW, 82950 QW, 82951 QW, 82952 QW, 83718 QW & 84478 QW Polymer Technology Systems CardioChek PA Analyzer (PTS Panels Metabolic Chemistry Panel Test Strips)	Polymer Tech Sys. Inc.	Measures HDL cholesterol, triglycerides, and glucose levels in whole blood.

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CPT Code/HCPCS Modifier & Test Name	Manufacturer	Use
85610 QW Roche Diagnostics CoaguChek XS	Roche Diagnostics	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for Vitamin K deficiency.
86318 QW Inverness Medical Clearview H. Pylori Test (whole blood)	Innovacon	Immunoassay for rapid, qualitative detection of IgG antibodies specific to <i>Helicobacter pylori</i> in whole blood.

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Ophthalmic Biometry: CPT Code 92136 Coding Guidelines

The following outlines how CPT code 92136 must be submitted when performed unilaterally or bilaterally.

CPT code 92136 and CPT code 92136 with HCPCS modifier TC are assigned the BILAT 2 indicator on the Medicare Physician Fee Schedule Database (MPFSDB), which means the payment is already calculated at the bilateral rate. **CPT code 92136 includes two technical components and one professional component.**

CPT code/modifier 92136-26 is assigned the BILAT 3 indicator on the Medicare Physician Fee Schedule Database (MPFSDB), which means the payment is calculated at the unilateral rate.

Performed Bilaterally:

If the technical and professional components were performed on both eyes on the same day, submit the claim as follows:

Date of Service	CPT Code/Modifier	Days/Units
7/3/2007	92136	"1"
7/3/2007	92136-26	"1"

If a bilateral technical component and a unilateral professional component were performed on the same day, but the other unilateral professional component was performed a different day, submit the claim as follows:

Date of Service	CPT Code/Modifier	Days/Units
7/3/2007	92136	"1"
7/10/2007	92136-26	"1"

Performed Unilaterally:

If CPT code 92136 or CPT code 92136 with HCPCS modifier TC is performed unilaterally, add CPT modifier 52 to indicate the bilateral procedure was performed on one eye only. (CPT code/modifier 92136-26 represents a unilateral service, so CPT modifier 52 is not appropriate for it.)

It is no longer necessary to submit documentation explaining use of CPT modifier 52 for CPT code 92136 or CPT code 92136 with HCPCS modifier TC. We will conclude that use of the modifier is intended to represent that the service was performed unilaterally.

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Submit the claim as follows:

Unilateral technical component:

Date of Service	CPT Code/Modifier	Days/Units
7/3/2007	92136-TC52	“1”

* TC is a HCPCS modifier and 52 is a CPT modifier.

or

Unilateral technical component and Unilateral professional component:

Date of Service	CPT Code/Modifier	Days/Units
7/3/2007	92136-52	“1”

or

Unilateral professional component:

Date of Service	CPT Code/Modifier	Days/Units
7/3/2007	92136-26	“1”

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CPT Modifiers 54 & 55

Date of Service and CPT Codes Must Match

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

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

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

Appropriate:

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

Inappropriate:

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

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

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

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

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Podiatry Services: Medicare Overview

Provider Types Affected

This article is for informational purposes only for providers billing Medicare for podiatry services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare Podiatry Services

Podiatry is defined as “the specialty concerned with the diagnosis and/or medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the human foot.” (*Stedman’s Medical Dictionary* 27th ed.)

This can include routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds, and infections.

Medicare Covered Podiatry Services

According to the *Medicare Benefit Policy Manual* (MBPM), Chapter 15, Section 290, Medicare Covered Podiatry Services only include medically necessary and reasonable foot care. Any other podiatry services that are offered would be considered routine care and would be classified as either Additional, Mandatory, Supplemental, or Optional Supplemental benefits.

Significant changes have been made in the Summary of Benefits. The category of “Medically Necessary Foot Care and Podiatry Services (Routine care)” has been merged into one category, “Podiatry Services.”

Please note that the treatment of **warts** (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Exclusions from Coverage

Certain foot care related services are not generally covered by Medicare, (though there are some exceptions where certain services will be covered). In general, the following services, whether performed by a podiatrist, osteopath or doctor of medicine, and without regard to the difficulty or complexity of the procedure, **are not covered by Medicare:**

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Podiatry Service Excluded	Exception To Exclusions (Covered by Medicare)
Routine Foot Care	<p>Initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.</p> <p>The presence of a systemic condition – such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine.</p> <p>Mycotic nails – In the absence of a systemic condition, treatment of mycotic nails may be covered when the physician attending the patient’s mycotic condition documents that:</p> <ul style="list-style-type: none"> • There is clinical evidence of mycosis of the toenail, and • The patient has marked limitation of ambulation, (for ambulatory patients) pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. <p>Routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition for the following:</p> <ul style="list-style-type: none"> • Diabetes mellitus • Chronic thrombophlebitis • Peripheral neuropathies involving feet associated with: <ul style="list-style-type: none"> ○ Malnutrition and vitamin deficiency such as malnutrition (general, pellagra), alcoholism, malabsorption (celiac disease, tropical sprue), and pernicious anemia ○ Carcinoma ○ Diabetes mellitus ○ Drugs and toxins ○ Multiple sclerosis ○ Uremia (chronic renal disease). <p>Although not intended as a comprehensive list, Chapter 15, Section 290 of the Medicare Benefit Policy Manual (Pub 100-2) lists some of the most commonly underlying conditions that might justify coverage for routine foot care.</p>
Flat Foot	None

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Podiatry Service Excluded	Exception To Exclusions (Covered by Medicare)
Subluxation of the Foot	Medical or surgical treatment of subluxation of the ankle joint (talo-crural joint). Reasonable and necessary medical or surgical services, diagnosis, or treatment for medical conditions that have resulted from or are associated with partial displacement of structures.
Supportive Devices for Feet	Orthotic shoes that are an integral part of a leg brace (the expense is included as part of the cost of the brace) . Therapeutic shoes for diabetic beneficiaries
Therapeutic Shoes for Individuals with Diabetes	A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes. (MBPM, chapter 15, section 140).

Presumption of Coverage for Routine Services

When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, please refer to the *Medicare Benefit Policy Manual (MBPM)*, Chapter 15, and Section 140.

When the routine services are **rendered by a podiatrist**, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot Care for Patients with Chronic Disease

Loss of Protective Sensation (LOPS)

Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

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Please refer to the *National Coverage Determination Manual*, Section 70.2.1, for additional information.

Treatments for Wound Care

Electrostimulation for Wounds (Claims submitted on or after July 6, 2004)

The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical and electromagnetic stimulation for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. All other uses of electrical and electromagnetic stimulation for the treatment of wounds are noncovered. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence.

Please refer to the National Coverage Decision: NCA for Electrostimulation for Wounds (CAG-00068R) for additional information. National Coverage Decisions are available at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=28> on the CMS Web site.

Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)

For claims submitted on or after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy **only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy** and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the National Coverage Determination (CAG-00060N). That document is available at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=37> on the CMS Web site.

Additional Billing Guidelines

Claims Involving Complicating Conditions

When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, **the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim**, along with the **approximate date** that the beneficiary was last seen by the indicated physician.

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Document carefully any convincing evidence showing that non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.

The exclusion of foot care is **determined by the nature of the service** and not according to who provides the service. When an itemized bill shows both covered services and noncovered services that are not integrally related to the covered service, the portion of the charges that are attributable to the noncovered services should be denied.

Sometimes payment is made for incidental noncovered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.

However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is “incident to” a covered procedure.

Information about coverage **Incident to Physician’s Professional Services** can also be found in the *Medicare Benefit Policy Manual*, Chapter 15, Covered Medical and Other Health Services, Section 60 - Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM, Chapter 15, Section 140)

Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.

These diabetic shoes are covered if the requirements specified in the *Medicare Benefits Policy Manual*, Chapter 15, Section 140, regarding certification and prescription are met.

This benefit provides for a pair of diabetic shoes, each equipped so that the affected limb, as well as the remaining limb, is protected even if only one foot suffers from diabetic foot disease.

Claims for therapeutic shoes for diabetics are processed by the durable medical equipment regional carriers (DMERCs). Therapeutic shoes for diabetics are not DME and are not considered DME nor orthotics, but a separate category of coverage under Medicare Part B.

Related Links

Medicare Manuals

- The *Medicare Benefit Policy Manual*, Publication 100-2, Chapter 15 can be found on CMS’ Web site at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>.
- The *Medicare Program Integrity Manual* can be found on CMS’ Web site at <http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf>.

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- The *Medicare Carrier Manual* can be found on CMS' Web site at <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021921>.
- The *National Coverage Determination Manual* can be found on CMS' Web site at <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=national&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS014961>.

Local Coverage Decisions

The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles can be found on CMS' Web site at http://www.cms.hhs.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P.

Related Change Requests and MLN Matters Articles

Program Memorandum Transmittal AB-02-096, Change Request 2269, "Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes" can be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/AB02096.pdf>.

Program Memorandum Transmittal AB-02-105, Change request 2272, "Medical Review of Medicare Payments for Nail Debridement Services," can be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/Downloads/AB02105.pdf>.

MLN Matters article, MM 3430, "Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses" can be found on CMS' Web site at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/mm3430.pdf>.

Bone Mass Measurements (BMMs)

Impact to You

Effective for dates of service on or after January 1, 2007, Medicare will pay for BMM services for dual-energy x-ray absorptiometry (CPT code 77080) when this procedure is used to monitor osteoporosis drug therapy. In addition, new CPT codes have been assigned to BMMs.

What You Need to Know

Medicare edits will deny claims that are not consistent with revised BMM policy and providers may be liable for noncovered BMMs unless they have issued an advanced beneficiary notice (ABN) as required. This article explains the changes as a result of the CY 2007 Physician Fee Schedule Final Rule.

What You Need to Do

See the remainder of this article for important information regarding billing Medicare for BMMs.

Background

This article and related Change Request (CR) 5521 wants providers to know that on June 24, 1998, the Centers for Medicare & Medicaid Services (CMS) published an Interim Final Rule with Comment Period (IFC) in the Federal Register entitled “*Medicare Coverage of and Payment for Bone Mass Measurements.*” This IFC implemented section 4106 of the BBA by establishing 42 CFR 410.31, Bone Mass Measurement: Conditions for Coverage and Frequency Standards. This new regulation defined BMM and individuals qualified to receive a BMM, established conditions for coverage under the “reasonable and necessary” provisions of 1862(a)(1)(A) of the Act, and established frequency standards governing when qualified individuals would be eligible for a BMM.

On December 1, 2006, CMS published the CY 2007 Physician Fee Schedule final rule which included changes to 42 CFR 410.31. These changes can be found in Chapter 15, Section 80.5 of the *Medicare Benefit Policy Manual* and in Chapter 13, Section 140 of the *Medicare Claims Processing Manual*. The revised manual sections are attached to CR 5221. The Web address for viewing CR 5221 is available in the “Additional Information” section at the end of this article.

Key Points

Listed is a summary of the revisions and additions to Chapter 13 of the *Medicare Claims Processing Manual* and Chapter 15 of the *Medicare Benefit Policy Manual*.

CHAPTER 13

Effective for dates of service on and after January 1, 2007, the CY 2007 Physician Fee Schedule final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry (SPA) as it is not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act.

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Effective for dates of services on and after January 1, 2007, the following changes apply to BMM:

New 2007 CPT bone mass codes have been assigned for BMM. The following codes will replace current codes; however, the CPT descriptors for the services remain the same:

- 77078 replaces 76070
- 77079 replaces 76071
- 77080 replaces 76075
- 77081 replaces 76076
- 77083 replaces 76078

BMM is not covered when a procedure other than dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will not pay for CPT codes 76977, 77078, 77079, 77081, or 77083 and HCPCS code G0103 when billed with the following ICD-9-CM diagnosis codes:

733.00	733.01	733.02	733.03	733.09	733.90	255.0
--------	--------	--------	--------	--------	--------	-------

BMM is covered when dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will pay CPT code 77080 when billed with the following ICD-9-CM diagnosis codes or any of the other valid ICD-9-CM diagnoses that are recognized by Medicare contractors appropriate for bone mass measurements:

733.00	733.01	733.02	733.03	733.09	733.90	255.0
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In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following Medicare Summary Notice (MSN) Messages, effective for services on or after January 1, 2007:

- MSN# 16.10: “Medicare does not pay for this item or service.”

If an Advance Beneficiary Notice (ABN) **was issued**, the following MSN will follow:

- MSN# 36.1: “Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.”

If an ABN **was not** issued the following MSN will be included:

- MSN # 36.2: “It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider’s bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.”

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Note: Medicare will not cover single photon absorptiometry and CPT code 75350 will be denied (using MSN# 16.10) for services on or after January 1, 2007.

Effective January 1, 2007, the following Remittance Advice (RA) Messages will be issued when Medicare denies BMM claims:

- Claim adjustment reason code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer".
- If an ABN was issued the RA issued is M38: "The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay."
- If an ABN was not issued RA remark code is M27: "The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office."

Advance Beneficiary Notices (ABNs) physicians, practitioners and hospitals are liable for payment unless they issue an appropriate ABN. **More information on ABNs may be found in Chapter 30, Sections 40-40.3.8 of the Medicare Claims Processing Manual, located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopofPage>.**

CHAPTER 15

Definition of BMM: a radiologic, radioisotopic, or other procedure that meets all of the following conditions:

- Is performed to identify bone mass, detect bone loss, or determine bone quality.
- Is performed with either a bone densitometer (other than single-photon or dual-photon absorptiometry) or a bone sonometer system that has been cleared for marketing for BMM by the Food and Drug Administration (FDA) under 21 CFR part 807, or approved for marketing under 21 CFR part 814.
- Includes a physician's interpretation of the results.

Conditions for Coverage

Medicare covers BMM if it is ordered by a qualified physician or non-physician practitioner, who is treating the beneficiary following an evaluation of the need for a BMM and the appropriate BMM to be used.

The BMM must be performed under the appropriate level of supervision as defined in 42 CFR 410.32(b).

The BMM must be reasonable and necessary for diagnosis and treatment of a beneficiary who meets at least one of the following conditions:

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- A woman who has been determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

NOTE: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an “adequate” dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a BMM is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than 3 months.
- An individual with primary hyperparathyroidism.
- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

In the case of any individual who is being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy, the BMM must be performed with a dual-energy x-ray absorptiometry system (axial skeleton).

In the case of any individual who meets the above conditions and who has a confirmatory BMM, the BMM is performed by a dual-energy x-ray absorptiometry system (axial skeleton) if the initial BMM was not performed by a dual-energy x-ray absorptiometry system (axial skeleton). A confirmatory baseline BMM is not covered if the initial BMM was performed by a dual-energy x-ray absorptiometry system (axial skeleton).

Frequency Standards

- Medicare pays for a screening BMM once every 2 years.
- Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:
 - Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months.
 - Confirming baseline BMMs to permit monitoring of beneficiaries in the future.
 - **Noncovered BMMs occur** when they are not considered reasonable and necessary under section 1862 (a) (1) (A) of the Act.
- Single photon absorptiometry (effective January 1, 2007).
- Dual photon absorptiometry (established in 1983).

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Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5521) issued to your Medicare carrier, FI or A/B MAC. That instruction consists of 3 transmittals, i.e.:

- Transmittal 69, which contains the Medicare National Coverage Determination, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R69NCD.pdf>;
- Transmittal 70, which contains the revised *Medicare Benefit Policy Manual* sections, is at <http://www.cms.hhs.gov/Transmittals/downloads/R70BP.pdf>; and
- Transmittal 1236 contains the *Medicare Claims Processing Manual* revisions and is at <http://www.cms.hhs.gov/Transmittals/downloads/R1236CP.pdf>.

A brochure outlining 'Bone Mass Measurements' is available at http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.pdf.

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

Scope of Portable X-Ray Benefit: Manual Instruction

Impact to You

Currently, the *Medicare Benefit Policy Manual*, Publication 100-02, chapter 15, section 80.4.3, relating to the scope of portable x-ray benefit is **not completely consistent with regulations at 42 CFR 410.32(c)(3)(i)**. The manual section states that “skeletal films involving arms and legs” are covered services under the portable x-ray benefit.

What You Need to Know

In order to make certain the manual conforms to the regulations, the Centers for Medicare & Medicaid Services (CMS) is revising the **manual to state that the benefit includes “skeletal films involving extremities”**. Although, the language differences are slight, the use of “**extremities**” in the regulation instead of “arms and legs” **delineates coverage beyond ‘arms and legs’ to the hands, feet, toes, fingers, wrist and ankle**. Language is also being added to **include the coverage of diagnostic mammograms, when certain requirements are met**.

What You Need to Do

Make certain that your billing staffs are aware of these changes. Also, be aware that Medicare contractors will adjust claims previously processed incorrectly, if you bring those claims to their attention.

Background

CR 5536 is the official document that announces these changes in Medicare processes. Attached to this document is the revised section of the *Medicare Benefit Policy Manual* section 80.4.3 - **Scope of Portable X-Ray Benefit** (Rev.71, Issued: May 25, 2007, Effective: N/A; Implementation: July 2, 2007) the manual revision reads as follows and the **bolded sections** are new :

In order to avoid payment for services, which are inadequate or hazardous to the patient, the scope of the covered portable x-ray benefit is defined as:

- Skeletal films involving **the extremities**, pelvis, vertebral column, *or* skull;
- Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations);
- Abdominal films which do not involve the use of contrast media; *and*
- **Diagnostic mammograms if the approved portable x-ray supplier, as defined in 42 CFR part 486, subpart C, meets the certification requirements of section 354 of the Public Health Services Act, as implemented by 21 CFR part 900, subpart B.**

Additional Information

For complete details regarding this Change Request (CR 5536), go to <http://www.cms.hhs.gov/Transmittals/downloads/R71BP.pdf>.

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

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

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

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

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

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

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

—Continued on next page

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Continued from previous page

Local Coverage Determination Updates

LCD	Change	Effective Date
Bone Mass Measurement 2001-37LR16	Addition of ICD-9 code V82.81 as medical necessity for CPT codes 76977, 77078-77081, 77083 and HCPCS code G0130. Use ICD-9 code V82.81 in addition to ICD-9 code V49.81 to denote that the qualified individual is a postmenopausal woman.	07/01/07
Chemodenervation 2001-25LR10	Addition of ICD-9 codes 307.81, 346.01, 346.11, 346.21, 346.81 and 346.91 to support medical necessity of CPT code 64613; HCPCS codes J0585 and J0587.	07/01/07

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Medicare Opt Out HPSA and/or PSA Bonus Program

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

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

Signature: _____

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

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

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

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

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

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

If you wish to Opt Out of the HPSA bonus and/or PSA bonus program,

please send completed form to:

Attention: Robert Reese, HPSA/PSA Specialist

Medicare Part B

Palmetto GBA

P.O. Box 182934

Columbus, Ohio 43218-2934

Or FAX completed form to:

Robert Reese, HPSA/PSA Specialist

614 - 473 - 6805

Palmetto GBA

Post Office Box 182934 • Columbus, Ohio • 43218-2934

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Redetermination Request for Medicare Part B Claims For Ohio & West Virginia

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



If you received a Medicare Redetermination on this claim DO NOT use this form to request further appeal. Your next level of appeal is a Reconsideration by a Qualified Independent Contractor (QIC). Use the form with your decision letter or use the appropriate reconsideration request form found on our Web site at <http://www.PalmettoGBA.com/boh/forms> (Ohio) or <http://www.PalmettoGBA.com/bwv/forms> (West Virginia).

If you received message MA-130 on the Medicare Remittance Notice for this claim, no appeal or reopening rights are available. Please submit a NEW claim with the appropriate corrections.

General Information

*Patient's name: _____ *** Indicates required fields.**

*Health Insurance Claim (HIC) number: _____ Provider Name: _____

Claim Number (ICN): _____ Billing provider number: _____

Date of initial determination: _____ Provider Phone Number: _____

*Date of Service: _____ Who are you:

*CPT code(s): _____ Provider

ICD-9 code(s): _____ Provider's Representative

Billed Charge: _____ Patient with Medicare

Patient's Representative

Other

This is an appeal for:

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

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

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

Reason for request: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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

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Reconsideration Request Form - QIC North (Ohio)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. At a minimum, **you must completed/include information for items 1, 2a, 6, & 7**, but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

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

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

Contractor Number: 00883

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

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Call Center

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

TTY 1-877-391-9739

Provider Enrollment Support Line

1-866-308-5439

Electronic Data Interchange (EDI) Technical Support

1-866-308-5438

Medicare Secondary Payer

1-866-308-5442

Telephone Reopenings

1-866-308-5441

Medicare Fraud Hotline

1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

<http://www.PalmettoGBA.com>

Important Sources For You

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

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

Attention: Billing Manager

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