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# Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2006, Issue 6

[www.cms.hhs.gov](http://www.cms.hhs.gov)

[www.PalmettoGBA.com](http://www.PalmettoGBA.com)

June 2006

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## You Are Responsible. . .



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

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

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## Medicare to Stop Mailing Standard Paper Remittance (SPR) for Those Providers/Suppliers Also Receiving the Electronic Remittance Advice (ERA)

Beginning June 1, 2006, the SPR received through the mail will no longer be available to providers/suppliers who also receive an ERA for 45 days or more, whether the ERA is received directly or through a billing agent, clearing house, or other entity representing a provider/supplier. In response to the provider/supplier communities' continued need for SPRs, CMS has developed free software called Medicare Remit Easy Print (MREP) that gives providers/suppliers a tool to read and print a remittance advice (RA) from the HIPAA compliant Health Care Claim Payment/Advice (835) file.

The MREP software was designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. CMS has worked with other payers to ensure their acceptance of the SPR generated by the MREP software for Coordination of Benefit claim submission. Additionally, CMS has worked with clearinghouses to assure similar software is available to read and print an ERA for those providers/suppliers that utilize clearinghouse services. We encourage providers/suppliers currently receiving the ERA, who don't use software to read and print RAs from these files, to begin using MREP or other similar software before the June 1<sup>st</sup> cutoff.

Please go to <http://www.PalmettoGBA.com/EDI/> for further information regarding MREP software. We appreciate your continued cooperation as the Medicare program moves toward a more electronic environment.

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# The Who, What, When, Why & How of NPI: Information for Health Care Providers

- **Who?** All Individuals and Organizations who meet the definition of health care provider as described at 45 CFR 160.103 are eligible to obtain a **National Provider Identifier**, or NPI. If you are a HIPAA covered provider or **if you are a health care provider/supplier who bills Medicare** for your services, you need an NPI.
- **What?** The NPI is a 10-digit number that will be used to identify you to your health care partners, including all payers, in all HIPAA standard transactions. The NPI will replace the identifiers you currently use in HIPAA standard transactions that you conduct with Medicare and with other health plans. **You will need an NPI prior to enrolling with Medicare.** There are two types of health care providers in terms of NPIs:
  - Type 1 - Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
  - Type 2 - Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.
- Organizations must determine if they have “**subparts**” that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization that furnishes health care and is not itself a separate legal entity.
  - If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself (Type 1) and an NPI for your corporation or LLC (Type 2).
- **When?** The NPI compliance date is **May 23, 2007**. However, CMS recommends that you obtain your NPI at least six months prior to this date to provide you with ample time to test your NPI and share it with all of your health care partners, including payers, clearinghouses, vendors, and other providers.
- **Why?** The NPI is an Administrative Simplification mandate of HIPAA.
- **How?** There are three ways that you can obtain your NPI. You can:
  - Complete the **on-line application** at the NPPES web site (<https://NPPES.cms.hhs.gov/NPPES/Welcome.do>);
  - Download the **paper application** form at <http://www.cms.hhs.gov/NationalProvIdentStand/> and mail it to the address on the form; or,
  - After asking you for your permission, authorize an employer or other trusted organization to obtain an NPI for you through bulk enumeration, or **Electronic File Interchange (EFI)**.Regardless of how you obtain your NPI, it is important that you **retain the notification document that NPPES sends to you** that contains your NPI. You may need to share this notification with other health care partners.
- **More:** Go to <http://www.cms.hhs.gov/NationalProvIdentStand/> to find additional NPI information.

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# Facilitating Your Medicare Enrollment

## Background

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these applications will be available only from the CMS provider enrollment Web site. The link for that CMS Web site is listed in the *Additional Information* section of this article.

## All Provider Enrollment Applications

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing.

Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application. In addition to providing the documentation previously required, all applicants are required to:

- Submit their National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and
- Complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

## Contractor Request for Additional Information

At any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application. Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

## Applications Received Through June 2, 2006

Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPPES. In addition, providers and suppliers who choose to use the 11/2001 version of the CMS-855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes.

Specifically, Section 1 must be completed by Physician Assistants and providers reassigning all of their benefits, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare Identification Number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4. —Continued on next page

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### **Applications Received On or After June 5, 2006**

All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-855.

### **Additional Information**

Special Edition article SE 0612 and SE 0632 contain helpful information about the Medicare enrollment process. You may review the article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf>, and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf>, respectively.

If you have any questions, contact the **Provider Enrollment Support Line** at 1-866-308-5439.

## **CMS Electronic Mailing Lists**

The CMS Electronic Mailing Lists (listservs) can help you with your business! For more details, download the Fact Sheet from the following url: [http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists\\_FactSheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf).

# Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications

## Background

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

## Key Points

This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

### Enhancements

- Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language;
- Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application;
  - Added tips on how to avoid delays in the enrollment process; and
  - Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

### Significant Changes

- Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application;
- Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information; and,
- Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

### Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS-855I form. In the past, such suppliers had to complete the CMS-855B, CMS-855I and CMS-855R. However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

### Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the requirement to collect crew member and certain vehicle information from ambulance companies **in Attachment 1 of the application.**

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- Revised the Independent Diagnostic Testing Facility information contained in Attachment 2 of the application.

#### **Application-Specific Changes for Institutional Providers (CMS-855A)**

- Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d) (2) (B) of the Medicare Modernization Act. See MLN Matters article SE 0582 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf> for further information.

#### **Additional Information**

Special Edition article SE 0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf>.

For additional information regarding the Medicare enrollment process, please contact our office at 1-866-308-5439.

# Provider Contact Center Training Closure Schedule

The Ohio/West Virginia (OH/WV) Medicare Part B Provider Contact Center will be closed for training from 8:30 a.m. until 12:00 p.m. on the first and third Friday of each month **except** September when we will close on the second and fourth Friday. Please note, our Interactive Voice Response unit (IVR) will still be available for automated customer service transactions. Refer to the training schedule below for specific closure dates and times for the quarter ending September 30, 2006:

Date	Phones Closed
Friday, July 7, 2006	8:30 a.m.-12:00 p.m.
Friday, July 21, 2006	8:30 a.m.-12:00 p.m.
Friday, August 4, 2006	8:30 a.m.-12:00 p.m.
Friday, August 18, 2006	8:30 a.m.-12:00 p.m.
Friday, September 8, 2006	8:30 a.m.-12:00 p.m.
Friday, September 22, 2006	8:30 a.m.-12:00 p.m.

Please note that we will provide at least a three-week advance notice of any changes to the above training schedule via the Web site, IVR features and automatic e-mail notices.

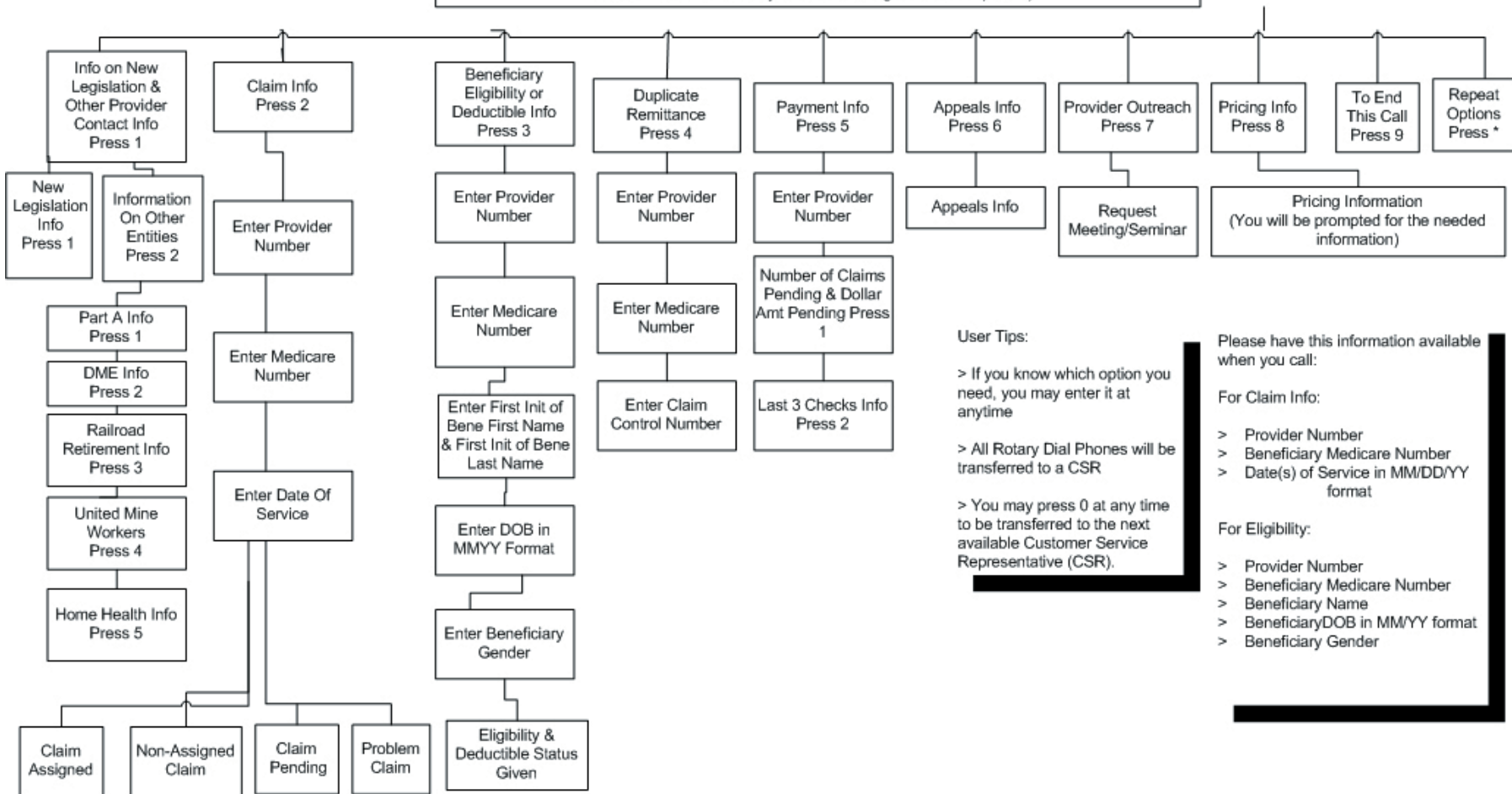
If you have not already done so, we would encourage you to sign up for automatic e-mail notices of newly posted online Palmetto GBA Medicare related information and newsletters. Being a subscriber on this listserv is the fastest way to find out about Medicare changes, which may affect you. There is no charge for the service and we will not share your e-mail address with others. To register, go to the e-mail update page on our Web site: <http://www.PalmettoGBA.com>, click “Register Now” and submit your registration and receive a confirmation.

If you have any questions, please contact the OH/WV Part B Provider Contact Center at 1-877-567-9232 (toll-free).

# Ohio Part B Provider Interactive Voice Response (IVR)

**To Access The OH/WV Part B Provider IVR  
Call 1-877-567-9232**

Pre-IVR Informational Messages  
Informational messages regarding new legislation and/or Medicare policies and procedures are provided for you. (Please note: These messages and options are changed periodically. Please listen to this entire announcement to assist you with selecting the correct options.)



**User Tips:**

- > If you know which option you need, you may enter it at anytime
- > All Rotary Dial Phones will be transferred to a CSR
- > You may press 0 at any time to be transferred to the next available Customer Service Representative (CSR).

Please have this information available when you call:

- For Claim Info:
- > Provider Number
  - > Beneficiary Medicare Number
  - > Date(s) of Service in MM/DD/YY format
- For Eligibility:
- > Provider Number
  - > Beneficiary Medicare Number
  - > Beneficiary Name
  - > BeneficiaryDOB in MM/YY format
  - > Beneficiary Gender

# Customer Service: How Important Is It to Palmetto GBA?

In August 2005, Palmetto GBA contracted with Scarlett Surveys International to conduct a survey of Medicare providers. Many of you who received this survey took the time to respond to it, and we would like to thank you for your continuing efforts as a partner in serving the Medicare community and for your time and responses. Customer service is very important to us and we value your feedback. Your feedback provides a valuable avenue to help us understand what we can do better to improve our overall service to you and the Medicare community. Now comes the key question: what are we going to do, as a result of your feedback? We want to show you how we will put your suggestions and feedback into action.

The 2005 survey results fall into 3 key categories: Communication/Education, Staff Knowledge, and Web site. Following is an overview of our plans for each of these categories.

## Web site

- Improve navigation, so that it's easier to find your way around our Web site.
- Improve the way our search engine functions, so that you get the results you want.

## Communication/Education

- Develop an interactive Internet-based tool for top problems (denials and rejections) and top questions.
- Enhance our specialty-specific and special-topic educational tools so that they are more readily available to you.
- Enhance MLN articles by adding information specific to Ohio and West Virginia providers.
- Develop tools designed to help you use the Interactive Voice Response (IVR) unit more efficiently and effectively.
- Clarify and simplify instructions for filing appeals.

## Staff Knowledge

- Implement a more consistent method of training staff on Medicare changes and new instructions.
- Improve our staff's ability to navigate our Web site, so that we can better help you locate the information you need.
- Increase staff knowledge of the appeals process, so that we can guide you through all of the required steps.
- Ensure and enhance staff knowledge with special proficiency tests.
- Analyze our responses to your questions to identify ways we can communicate more clearly and effectively to meet your needs.

## Your Feedback

The exciting news is that we have already begun much of the work needed to implement these actions. Some of them will take time, and we will work diligently to ensure that all are completed. In the meantime, we are keeping our eyes and ears open for new and better ways of helping you understand the Medicare program and working to meet your needs!

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## Overpayments to a Physician/Supplier or Patient when Medicare is the Secondary Payer

There are times when both Medicare and another insurer make a primary payment to a provider, physician or other supplier. This is considered a Duplicate Primary Payment. When a Duplicate Primary Payment occurs, it is an indication that Medicare should have been the secondary payer. When you identify a Duplicate Primary Payment, send your check along with a copy of the other insurers Explanation of Benefits and attach those items to the Medicare Part B Refund / Overpayment Form and mail to:

Palmetto GBA  
Debt Collection Unit  
P.O. Box 182934  
Columbus, Ohio 43218-2934

The Medicare Part B Refund / Overpayment Form is available at our PalmettoGBA.com Web site. To access, go to <http://www.PalmettoGBA.com/boh> (Ohio) or <http://www.PalmettoGBA.com/bwv> (West Virginia), and select Resources, Forms. To assure that your refund check is handled properly, please use this form and attach the other insurers Explanation of Benefit along with the check.

**NOTE:** If you send a refund check without the other insurers Explanation of Benefit, Medicare may apply the refund to other outstanding account receivables for you.

When a Duplicate Primary Payment situation occurs, refund to the beneficiary any Medicare deductible and coinsurance amounts paid by the beneficiary that were duplicated by the primary payment. If the primary payment exceeds the deductible and coinsurance amounts, the excess constitutes a debt to Medicare because it duplicates all or part of the amount Medicare has paid. Also, the Code of Federal Regulations (42 CFR 411.24(h) and 411.25) requires repayment to Medicare first regardless of which payment was received first, even if the insurance payment was refunded to the beneficiary or the insurer.

42 CFR 489.20 requires the provider, physician or other supplier to refund Medicare within **sixty (60) days from receipt of the other insurer (primary to Medicare) payment.**

If Medicare identifies the overpayment, we will issue a written request for the refund to the provider, physician or supplier depending upon who received the other payment. If the full amount is not refunded within forty (40) days from the date of the written request, an offset from other payable benefits will occur. In addition, interest will be assessed on the outstanding principal balance every thirty (30) days until full payment is received.

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# Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens ~ Section 1011

## Impact on Providers

You may not be receiving funds that are available to you for services you furnish to undocumented aliens, and the Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to inform and/or remind you about these available funds.

## What You Need to Know

The Medicare Prescription Drug Improvement and Modernization Act (MMA) (Section 1011) provides \$250 million each year for Fiscal Years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens. You may be eligible to receive some of these funds.

## Background

CMS previously issued MLN Matters Special Edition article SE 0535 (MMA – CMS' Implementation of Section 1011 of the Medicare Modernization Act – Federal Funding of Emergency Health Services Furnished to Undocumented Aliens) to inform physicians, hospitals, and ambulance services about the federal funding available to help pay for services furnished to undocumented aliens. (See SE 0535 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0535.pdf>.)

Because some providers may not be utilizing these available funds, CMS is issuing this additional special edition article to inform (and remind) providers about the funds that are available for emergency health services furnished to undocumented aliens.

The MMA (Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens) provides \$250 million each year for Fiscal Years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens:

- Two-thirds of the funds are divided among all 50 states and the District of Columbia, based on their relative percentages of undocumented aliens; and
- One-third of the funds are divided among the six states with the largest number of undocumented alien apprehensions.

**Note:** Current state allocations of these funds may be viewed at [http://www.cms.hhs.gov/UndocAliens/04\\_state\\_alloc.asp#TopOfPage](http://www.cms.hhs.gov/UndocAliens/04_state_alloc.asp#TopOfPage).

From the respective state allotments, payments are made directly to enrolled hospitals, physicians, and ambulance providers for some or all of the costs of providing emergency health care (required under Section 1867) and related hospital inpatient services, outpatient services, and ambulance services provided to eligible individuals.

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As of May 1, 2006, nationally, over 9,000 provider enrollment applications have been approved. The first Section 1011 payment to providers was issued on February 27, 2006, totaling nearly \$25.5 million, and the next quarterly payment to providers will be made on May 29, 2006.

TrailBlazer Health Enterprises, LLC, is the national contractor for the Section 1011 program and is the only contractor for processing all requests for Section 1011 provider payments. So, if you want to request 1011 payments, you must do so by enrolling with TrailBlazer and then submit your requests to TrailBlazer. **Do NOT submit requests for 1011 payment to your regular fiscal intermediary or carrier.** To learn more about the Section 1011 program, or to enroll as a provider, see the TrailBlazer Web site at <https://www.trailblazerhealth.com/section1011/>. TrailBlazer can also be contacted directly by telephone at (866) 860-1011.

### **Additional Information**

Additional information regarding Section 1011 of the MMA and CMS' policy for the implementation and administration of this program can be found at <http://www.cms.hhs.gov/UndocAliens/>.

# Hold on Medicare Payments

This article replaced Change Request (CR) 4349, which was rescinded.

## Key Points

- A brief hold will be placed on Medicare payments for ALL claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer (MSP) claims) for the last 9 days of the Federal fiscal year, i.e., September 22, 2006-September 30, 2006.
  - In essence, no payments on claims will be made from September 22-30, 2006. Providers need to be aware of these payment delays, **which are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006.**
  - Accelerated payments using normal procedures will be considered.
- No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- All claims held as a result of this one-time policy that would have otherwise been paid on one of these 9 days will be paid on **October 2, 2006.**

## Additional Information

**This policy applies only to claims subject to payment.** It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments.

Additionally, Medicare contractors will continue to apply the 14-day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare FIs, RHHIs or carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Please note that:

- Payments will not be staggered; and
- No advance payments during the 9-day hold will be allowed.

CR 5047 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR 5047 may be found by going to CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf>.

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

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## Repeat or Duplicate Services on the Same Day

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

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

When a correction is needed on a previously paid service, do not submit as a new claim. Palmetto GBA can “reopen” these claims, at your request. Please write to:

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

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

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

- Submit multiple, identical services on the same claim. If you submit more than one claim for the same service, you can expect identical services to be denied.
- Use the Days/Units Field. Submit services on one claim using the Days/Units field.
- Indicate the times of each service in the appropriate documentation record for electronic claims or Item 19 of the CMS-1500 claim form.

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

### Example:

Patient receives two chest x-rays on October 1, 2005, interpreted by the *same physician*. The first interpretation is performed at 10:00 a.m. and the interpretation of the second x-ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	71010-26	2

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### Modifiers

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

### Site Modifiers:

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

### Example:

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

Submit as:

Date of Service	CPT Code/HCPCS Modifier	Days/Units
10/1/05	28010-T1	1
10/1/05	28010-T3	1

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

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

### Example:

Patient receives three chest x-rays on October 1, 2005, by the *same physician*. The first x-ray is performed at 10:00 a.m., the next one at 12:00 p.m., and a follow-up x-ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	71020	1
10/1/05	71020-76	2

OR submit as:

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

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

**Example:**

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

Submit as:

Claim #1 – Dr. A

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

Claim #2 – Dr. B

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

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

**Example:**

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

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	82746	1
10/1/05	82746-91	1

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# You've Got a Friend

Are you down and troubled with all the changes in the Medicare program? Do you need a helping hand? Palmetto GBA is willing and able to guide you through. Sign up today for email updates - it's FREE!

Just go to our Web site, <http://www.PalmettoGBA.com>. Once you register and select the topics that apply to your practice under Ohio/West Virginia Part B, you'll receive all the current Medicare information that's important to you.

Don't delay, sign up today!

# 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
- ✓ And so much more!
- ✓ Fee Schedule changes
- ✓ LCD/NCD changes

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**

<b>User Name (email address)</b>	
<b>Print First and Last Name</b>	
<b>Password</b>	S3cret*1
<b>Your Address</b>	
<b>Second Line (if needed)</b>	
<b>City/State/Zip</b>	
<b>Your E-mail Address</b>	
<b>Phone number with area code</b>	

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

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

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# Health Professional Shortage Area (HPSA) & Physician Scarcity Area (PSA) Bonus Billing for Some Globally Billed Services

## Provider Action Needed

This article is based on Change Request (CR) 5015, which will allow physicians to submit global services and receive the HPSA and PSA bonuses without having to submit the professional component and technical component (PC/TC) separately.

## Background

Currently, components of services with a professional component/technical component of four must be submitted separately in order to receive the HPSA and PSA bonus payments. CR 5015 is similar to CR 4266 (Transmittal 834) in that it also allows you to submit the global service and receive the bonus payment on all professional component/technical component (PC/TC) 4 codes.

However, CR 5015 further instructs that payment is excluded for the following Current Procedural Terminology (CPT) code:

**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)

**Note:** The “technical component” of services relates to facilities, equipment, and technical staff required for the delivery of those services, and the “professional component” consists of fees paid to the physician for providing those services. When combined, the “professional and technical” components of a service are referred to as “global” service.

CR 5015 instructs that, effective for claims received on or after July 1, 2006:

- When your carrier receives a claim for a service with a PC/TC of 4, **except for CPT code 93015**; and
- The service is provided in a HPSA or PSA bonus payment area; then
- Your claim will be accepted.

The bonus payment amount is calculated based on the payment amount for the associated professional component code.

Your carrier will make any necessary revision to their systems to be able to calculate the bonus payment just for the professional component of the service. This action will be taken for bonuses paid automatically as well as bonuses paid based on the submission of the QB, QU, AR, or AQ HCPCS modifiers.

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Because there are two associated professional components to CPT code 93015, your carrier will follow the instructions in the *Medicare Claims Processing Manual* and **return claims for CPT code 93015 as unprocessable**. The services must then be resubmitted as separate components in order to receive the bonus on the appropriate professional component.

Carriers will continue to allow the option of withholding HPSA/PSA bonuses if that is requested by physicians and the carriers will not pay the bonus on PCTC 4 to physicians who have already notified them of their decision to not receive HPSA/PSA bonuses.

**Note:** CR 5015 does not affect current HPSA or PSA payment policy.

### **Implementation**

The implementation date for the instruction is July 3, 2006.

### **Additional Information**

The revised *Medicare Claims Processing Manual* - Publication 100.4, Chapter 12 (Physician Practitioner Billing), Section 90.4.5 (Services Eligible for HPSA and Physician Scarcity Bonus Payments), is attached to CR 5015, which is the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R906CP.pdf>.

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

## HPSA Location Changes

The following changes have been made for the HPSA locations, which were also documented in the CMS Quarterly HPSA location list.

### Ohio Geographic HPSA

County	Effective Date	Added or Deleted
<b>Harrison County</b>	4/10/2006	Added
Cadiz/Scio/Hopedale Archer Township Athens Township Cadiz Township Franklin Township German Township Green Township Monroe Township North Township Rumley Township Short Creek Township Stock Township		

### West Virginia Geographic HPSA

County	Effective Date	Added or Deleted
Mingo County	4/14/2006	Added

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# HPSA Alert

Jackson County West Virginia is currently a designated HPSA area. At this time the HPSA database located at <http://www.hrsa.gov> does not include the county although if you select the advanced search option, Jackson County is listed as eligible for the bonus.

The Health Resources and Services Administration (HRSA) Web site contains two features. The advance feature link/database identifies Jackson County, West Virginia as a proposed HPSA withdrawal. At this time, Jackson County, West Virginia, remains a geographic HPSA.

- Providers who render services within Jackson County who are not on the automatic ZIP Code payment list should continue to submit the HCPCS modifier QB or QU to receive the bonus for services provided on or after January 1, 2006.
- For services on or after January 1, 2006, the HCPCS modifier AQ must be submitted to be eligible to receive the 10% incentive bonus.
- Providers who render services within Jackson County who are on the automatic ZIP Code payment list do not need to use a modifier to receive the bonus.

**Source:** Health Resources and Services Administration, National HPSA Database and CMS, HHS Bureau of Health Professions.

## Unprocessable Claims Coding Reminders

Assigned and non-assigned claims are considered unprocessable when incomplete or invalid information is detected in our claims processing system. Depending on how the claim is submitted to Medicare, the claim is rejected using one of the following methods:

- Message Code MA130 appears on your Remittance Advice indicating the claim is unprocessable.
- The claim is returned to you with a form letter indicating the incomplete or invalid information.

**Reason and Remark Code lists are available at the following Web site:** <http://www.wpc-edi.com>.

**A Written Redetermination or Telephone Reopening should not be requested. Rejected claims must be corrected and retransmitted/resubmitted as NEW claims. There are no appeal rights on rejected claims.**

If you need further information about why the claim was rejected as unprocessable, contact the Provider Contact Center at 1-877-567-9232.

Additional information regarding Unprocessable Claims, is available on the Centers for Medicare and Medicaid Services (CMS) Web site (Refer to Section 80.3.1): <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.

Also, check out Palmetto GBA's Topo Claim Submission Error article on our Web site. To access, go to <http://www.PalmettoGBA.com/boh> (Ohio) or <http://www.PalmettoGBA.com/bwv> (West Virginia), and select Resources, FAQs, and Customer Service.

### Medicare Prescription Drug Coverage (Part D) Web Pages

NEW! Visit <http://www.cms.hhs.gov/center/provider.asp> and scroll down to "Part D Tools for Health Care Professionals" for a comprehensive list of links to agency-wide resources for providers on Medicare Rx coverage. These resources can help providers and office staff access direct phone numbers to a Medicare drug plan's coverage determination staff, as well as obtain model forms that will help speed the process. Additionally, a new fact sheet, as well as other educational products for the FFS community, is now available at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp> on the CMS Web site.

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# How Does Palmetto GBA (OH/WV) Use Invoices to Reimburse Drugs and Biologicals?

Drugs and biologicals are reimbursed using one of several methodologies:

- Average Sales Price (ASP)
- CMS Not Otherwise Classified (NOC) Pricing File
- Wholesale Acquisition Cost (WAC) or invoice pricing
- Other pricing methodology (employed for radiopharmaceuticals)

For drugs and biologicals reimbursed using **ASP methodology**:

- Payment is based on 106% of the ASP.
- There are several exceptions to the ASP payment methodology, including: blood and blood products; drugs infused through a covered item of Durable Medical Equipment, and certain vaccines.
- ASP and NOC pricing files are available at: <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>

For drugs or biologicals reimbursed using **WAC or invoice pricing**:

- WAC pricing applies to drugs that are not reimbursed based on ASP or the NOC Pricing File.
  - When **WAC pricing** is available, Palmetto GBA will base the reimbursement on the WAC amount from the Redbook. ***No invoice is needed when a WAC amount is available.***
  - The payment limit is based on the lesser of the lowest brand or median generic WAC.
  - The payment allowance for new drugs that were first sold on or after January 1, 2005 is based on 106% of the WAC.
  - Information on determining WAC pricing is available in CMS Pub. 100-04, chapter 17 (<http://www.cms.hhs.gov/manuals>).
- When **invoice pricing** is used, each Medicare contractor determines how many invoices are necessary to determine the reimbursement amount.
  - **Palmetto GBA requires that invoices be submitted *with each claim***, when the drug or biological is not priced based on ASP and there is no WAC available.

For **radiopharmaceuticals**:

- Reimbursement for radiopharmaceuticals is based on 95% of the Average Wholesale Price (AWP).
- This pricing methodology was in place in November 2003 and is currently used to determine reimbursement for radiopharmaceuticals.

## References:

### **Laws**

- Social Security Act, section 1847A(c)(4) ([http://www.ssa.gov/OP\\_Home/ssact/title18/1800.htm](http://www.ssa.gov/OP_Home/ssact/title18/1800.htm))
- Medicare Modernization Act of 2003, section 303(c). Find out more about how CMS is implementing this legislation at: <http://www.cms.hhs.gov/MMAUpdate/>.

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**CMS**

- For information regarding ASP reimbursement methodology: CMS Change Request (CR) 4319 (<http://www.cms.hhs.gov/transmittals>, 2006, CR 4319) and the related *MLN Matters* article (<http://www.cms.hhs.gov/MLNMattersArticles>, 2006, MM 4319).

**Palmetto GBA**

- For other helpful information on drugs and biologicals, refer to <http://www.PalmettoGBA.com/boh> (Ohio) or <http://www.PalmettoGBA.com/bwv> (West Virginia):
  - Articles, Drugs & Biologicals
  - Physician/Supplier Guide: Drugs & Biologicals

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# Coverage of Prescription Niacin Products Under Part D for 2006

## Key Points

- On April 11, 2006, the Centers for Medicare & Medicaid Services (CMS) informed Medicare Part D prescription drug coverage plans, via a memorandum titled “CMS Clarification of Coverage of Prescription Niacin Under Part D,” that was issued over the Health Plan Management System (HPMS), that prescription Niacin products (Niaspan®, Niacor®) can be a covered Part D drug for treatment of dyslipidemic therapy and may be included on Medicare prescription drug plan formularies. Medicare prescription drug plans have the option of covering those drugs immediately.
- For the remainder of contract year 2006, Medicare Part D plans may put prescription Niacin products (Niaspan®, Niacor®) on their formularies, but they are not required to do so. As a result, enrollees may obtain coverage of prescription Niacin products either as a formulary drug or as a non-formulary drug through the exceptions process.
- For contract year 2007, prescription Niacin products (e.g., Niaspan® and Niacor®) used at dosages much higher than appropriate for nutritional supplementation should be considered for formulary inclusion similar to all other Medicare Part D drugs.
- Please refer to the Additional Information section of this Special Edition article for specific information regarding two methods for Part D Medicare beneficiary enrollees to obtain prescription Niacin products for the remainder of 2006.

## Background

The prescription Niacin products are used therapeutically for the treatment of dyslipidemia at much higher dosages than are appropriate for nutritional supplementation. They do not serve as a nutritional supplement or to address a vitamin deficiency. For these reasons, CMS has decided that prescription Niacin products should not be considered a prescription vitamin for purposes of Medicare Part D coverage.

Prescription Niacin products are not universally excluded from coverage under the Medicare prescription drug program. This reverses an earlier February 3, 2006, decision by CMS that prescription Niacin products (Niaspan®, Niacor®) are prescription vitamins and therefore are excluded from the definition of a Medicare Part D drug under the statute.

## Additional Information

### Prescribing Prescription Niacin products (Niaspan®, Niacor®) for the Remainder of 2006

For Medicare beneficiaries in plans that INCLUDE prescription Niacin products on their formulary:

- If prescription Niacin products are not subject to prior authorization – a Medicare prescriber writes a prescription for the prescription Niacin product and the Part D enrollee has the prescription filled at a local retail pharmacy or a mail order pharmacy. If the enrollee is a resident of a long term care facility, the prescription will be filled by the long term care pharmacy serving that facility.
- If prescription Niacin products are subject to prior authorization the Medicare prescriber must file a prior authorization request on behalf of the enrollee. Each Medicare Part D plan has its own form, available on the plans’ web sites (some plans have specific forms for particular drugs; others use a standard prior authorization form).

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- Plans must approve or inform the enrollee why they have disapproved a prior authorization request within 72 hours. An enrollee or an enrollee's physician can request an "expedited coverage determination" for a decision within 24 hours if the enrollee's health, life, or ability to regain maximum function may be seriously jeopardized by waiting 72 hours for a decision.
- If a Medicare Part D plan disapproves a prior authorization request (i.e., makes an "adverse coverage determination"), the enrollee has the right to request a redetermination from the plan sponsor (see below).

For plans that **do not** have prescription Niacin products (Niaspan®, Niacor®) on their formularies:

- If a Medicare beneficiary is currently taking a prescription Niacin product and is enrolled in a Medicare Part D plan that does not include prescription Niacin products on its formulary, the beneficiary can now ask for an exception to get coverage for a prescription Niacin product (see below).
- If a Medicare beneficiary who is currently taking a prescription Niacin product enrolls in a Medicare Part D plan that does not include prescription Niacin products on its formulary, the plan is required to have a process to ensure the enrollee's smooth transition into the plan and to allow the enrollee time to obtain medically necessary exceptions to the plan's formulary.
- Many Medicare Part D plans have adopted a "first fill" policy that will allow enrollees to have their first prescription for the prescription Niacin product filled even if prescription Niacin product are not on the plan's formulary. This will allow Medicare beneficiaries who have been stabilized on a prescription Niacin product to continue taking it while they request exceptions.
- The transition process is a very temporary solution, however, and enrollees and providers should not delay pursuing exceptions. Prescribers may advise enrollees to contact their plans for more information about their plan's transition process.

### **Exceptions and Appeals**

If a physician prescribes a non-formulary drug for an enrollee, the enrollee or physician must request an exception, which is a type of coverage determination, to obtain the non-formulary drug for the enrollee. If the plan sponsor's coverage determination is unfavorable, the enrollee may appeal the plan sponsor's decision.

### **Exceptions**

An enrollee or an enrollee's physician has the right to request an exception for coverage of non-formulary prescription Niacin products. The enrollee's prescribing physician should submit a statement supporting the exception request. The Part D plan must notify the enrollee of its decision within 72 hours after receiving the physician's supporting statement. If the enrollee or physician requests an expedited decision, the plan sponsor must notify the enrollee of its decision within 24 hours after receiving the physician's supporting statement if the plan determines, or the enrollee's physician indicates, that applying the 72-hour timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

The plan must grant the exception if it determines that the requested drug is medically necessary, consistent with the physician's statement. The Medicare provider physician's statement must state that the exception is

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medically necessary to treat the Medicare beneficiary enrollee's disease or medical condition because all of the covered Medicare Part D drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective as prescription Niacin products, would have adverse effects, or both.

## **Appeals**

If a plan sponsor issues an adverse coverage determination, the decision may be appealed. There are five successive levels of appeal.

- If a plan sponsor issues an unfavorable coverage determination, the enrollee has the right to request a standard or expedited redetermination with the plan sponsor within 60 calendar days from the date of the notice of the plan sponsor's adverse coverage determination. Enrollees or their prescribing physician can submit written evidence and legal arguments for coverage of prescription Niacin products during the redetermination process. The plan sponsor must notify the enrollee of its decision within 7 calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- If the plan sponsor's redetermination decision is unfavorable, the enrollee has the right to request reconsideration by the independent review entity (IRE) that contracts with CMS. This request must be submitted in writing within 60 calendar days from the date of the notice of the plan sponsor's adverse redetermination decision. The IRE must solicit the views of the prescribing physician orally or in writing and must notify the enrollee of its decision within 7 calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- If the IRE denies the request for coverage and the amount remaining in controversy is at least \$110, the Medicare beneficiary enrollee has the right to request a hearing before an Administrative Law Judge (ALJ). The request must be filed in writing within 60 calendar days from the date of the notice of the IRE's adverse reconsideration determination.
- If the ALJ's decision is unfavorable, the enrollee has the right to request a review by the Medicare Appeals Council. The request must be filed in writing within 60 calendar days from the date of the notice of the ALJ's adverse decision.
- If the MAC issues an adverse decision, the enrollee has the right to request judicial review of the ALJ's decision by filing a civil action in U.S. District Court if the amount remaining in controversy is at least \$1,090. The request must be filed in writing within 60 calendar days from the date of the notice of the MAC's adverse decision.

For additional information, CMS has a number of MLN Matters special edition articles on the new drug program, especially the fourth and fifth articles in the MLN Matters series about Medicare's new prescription drug coverage. SE 0537, *New Educational Products Available*, is the fourth article in the series and can be found on CMS' Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0537.pdf>.

SE 0541, *More Web-based Educational Products Available on Medicare Prescription Drug Coverage*, is the fifth article in the series. It is available on CMS' Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0541.pdf>.

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# Competitive Acquisition Program (CAP) for Part B Drugs Coding, Testing, and Implementation

**Note:** this article was revised on May 8, 2006, to reflect that the election period for physicians to participate in the CAP this year will run from May 8, 2006, to June 2, 2006.

## Provider Action Needed

From May 8, 2006, to June 2, 2006, Medicare physicians will be given the opportunity to elect to participate in the Competitive Acquisition Program (CAP) for claims paid on or after July 1, 2006. Participating CAP physicians will obtain Medicare Part B covered drugs from selected drug categories through the CAP. Until further notice, there is only one drug category in the CAP.

(**Note:** Exact dates of the physician election period will be announced on the comp bid Web site (<http://www.cms.hhs.gov/CompetitiveAcquisforBios>) and via a listserv notice).

## What You Need to Know

Participating CAP physicians will receive all of their Part B drugs from the approved CAP vendor for the drug category (ies) they have selected.

The only exception is the “**furnish as written**” situation, in which the participating CAP physician requires that, because of medical necessity, the beneficiary must have a certain brand of a drug or a particular product identified by the product’s National Drug Code (NDC) and that specific drug is not available for the HCPCS code listed on the approved CAP vendor’s drug list. This one exception will be identified with the use of the new CAP J3 HCPCS modifier. **Physicians participating in the CAP program should pay particular attention to the discussion in this article concerning the CAP J1, J2, and J3 HCPCS modifiers.**

## What You Need to Do

By May 1, the Centers for Medicare & Medicaid Services (CMS) will post on its web site a list of the CAP vendors and the drugs they will supply. Physicians wishing to participate in the CAP program in 2006 must elect to do so within 45 days of the date the election information is posted. The election agreement is effective on July 1, 2006. See the Background section of this article for further details regarding these changes.

## Background

This article includes information from Change Request (CR) 4064, which provides instructions to Medicare carriers regarding the CAP program. This new CAP program applies to physician-injectable and infused drugs covered under Medicare’s Supplemental Insurance (Part B) program that are commonly provided incident to a physician’s service. This program does NOT apply to drugs included in the new Prescription Drug Benefit under Part D, which goes into effect on January 1, 2006.

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Physicians (and other practitioners who provide physician services that include the authority to prescribe and order Medicare Part B drugs) wishing to participate in the CAP program in 2006 must elect to do within 45 days of the date that the election information is posted on the CMS Web site.

The election agreement is effective on July 1, 2006. Each subsequent year, the election period will be in the fall and physicians must make their participation decision within 45 days after CMS publishes the list of vendors and their drug list for the following year on the CMS Web site. Election decisions will take effect on the following January 1.

### **How Drugs Are Selected For CAP**

The CMS may exclude drugs from the CAP if competitive pricing will not result in significant savings, or is likely to have an adverse impact on access to such drugs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gives CMS the authority to:

- Select drugs (or categories of drugs) that will be included in the CAP program,
- Establish geographic competitive acquisition areas, and
- Phase in these elements as appropriate.

### **How Approved CAP Vendors Are Selected**

A competition will be held every three years to award contracts to vendors that will supply drugs and biologicals for the program. A three year contract will be awarded to qualified approved CAP vendors in each geographic area who have and maintain:

- Sufficient means to acquire and deliver competitively biddable drugs within the specified contract area;
- Arrangements in effect for shipping at least 5 days each week for the competitively biddable drugs under the contract and means to ship drugs in emergency situations;
- Quality, service, financial performance, and solvency standards; and
- A grievance and appeals process for dispute resolution.

Approved CAP vendors must qualify for enrollment as a Medicare supplier, and they will be enrolled as a new provider specialty type.

CMS will establish a single payment amount for each of the competitively bid drugs and areas. For this three year contract cycle there will be one drug category and one geographic area for CAP. After CAP drug prices are determined and vendor contracts are awarded, the information will be posted to a directory on CMS' Web site at <http://www.cms.hhs.gov/CompetitiveAcquisforBios>.

### **Obtaining Drugs in the CAP**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 303 (d)) requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or Prospective Payment System basis. You can review the MMA, Section 303(d) at CMS' Web site at <http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/303d.pdf>.

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Beginning with Part B drugs administered on or after July 1, 2006, incident to a physician service, Medicare physicians will be given a choice between:

- Buying and billing these drugs under the Average Sales Price (ASP) system; or
- Obtaining these drugs from vendors selected in the CAP's competitive bidding process.

Physicians (and other practitioners who provide physician services that include the authority to prescribe and order Medicare Part B drugs) will be given the opportunity to participate in the CAP. Approved CAP vendors will supply the drugs and biologicals for the participants of this program. Physicians who elect to participate in CAP will continue to bill their local carrier for drug administration.

Participating CAP physicians will receive all of their drugs from the approved CAP vendor for the drug categories they have selected, **with only one exception:**

The exception will be for **“furnish as written”** situations in which the participating CAP physician specifies that, because of medical necessity, the beneficiary must have a certain brand of a drug or a particular product defined by the product's National Drug Code (NDC) and that drug is not available for the HCPCS codes listed on the approved CAP vendor's drug list.

In those cases, the participating CAP physician may:

- Buy the drug;
- Administer it to the beneficiary; and
- Using the appropriate modifier (see below discussion of modifiers), bill Medicare using the average sales price (ASP) methodology.

In addition, under emergency situations, the CAP will allow a participating CAP physician to provide a drug to a Medicare beneficiary from his or her own stock and obtain the replacement drug from the approved CAP vendor under the emergency replacement provision when certain conditions are met as follows:

- The drug was required immediately;
- The need for the drug could not be anticipated;
- The CAP vendor could not deliver the drug in time;
- The drug was administered in an emergency situation; and
- Documentation is maintained on file to validate these conditions.

**Note:** Physicians will still be able to continue to purchase and bill Medicare under the Average Sales Price (ASP) system those drugs that are covered under Medicare Part B but whose HCPCS codes are not provided by the chosen approved CAP vendor.

### **Physician Billing**

Physicians will be given the opportunity to participate in the CAP on an annual basis, and those who elect to participate in CAP will continue to bill their local carrier for the drug's administration. They will agree to submit a claim to Medicare within 14 days of the administration of the CAP drug.

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The carrier will deny any physician Part B claims for drugs included in the CAP unless the CAP modifier codes are appropriately included. CAP has three modifier codes that will need to be used when physicians submit claims to their carriers for the administration of CAP drugs. The new CAP HCPCS modifier codes are:

- J1 – Competitive Acquisition Program, no-pay submission for a prescription number
- J2 – Competitive Acquisition Program (CAP), restocking of emergency drugs after emergency administration and a prescription number
- J3 – Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under average sales price (ASP) methodology.

Participating CAP physicians will also use a prescription/order number to identify each CAP drug administered. This number will be matched to the prescription/order number(s) on the approved CAP vendor's claim as verification that the beneficiary received the drug(s) and that the approved CAP vendor may now be paid by Medicare.

When physicians submit claims for the administration of CAP drug (s) to their carriers, they should include:

- A prescription/order number for each CAP drug administered;
- The HCPCS code for each CAP drug administered along with the new J1 no-pay HCPCS modifier;
- The HCPCS code(s) that include the administration of each CAP drug on separate lines.

**Note:** On paper claims, the prescription numbers will be in Item 19.

When physicians submit claims for the administration of CAP drug(s) that have been administered in an emergency situation and required "emergency restocking" from the approved CAP vendor, the claim should be submitted with the:

- Prescription/order number for each CAP drug administered;
- HCPCS code for each administered CAP drug along with the new J1 no-pay HCPCS modifier and also on that same line, the new J2 HCPCS modifier denoting "Competitive Acquisition Program, (CAP) restocking of emergency drugs after emergency administration;" and
- HCPCS code(s) that include the administration of each CAP drug on separate lines.

When physicians submit claims for "**furnish as written**" drugs to be paid outside the CAP program:

- Physicians should use only the new HCPCS modifier J3 denoting "Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under the average sales price methodology."

Physicians who elect CAP should note:

- The administration services and the no-pay lines must be on the same claim or your carrier will return the claim as unprocessable and you will see a remittance advice reason code of 16 denoting claim lacks information which is needed for adjudication.
- The Medicare carrier will identify them as physicians who elected to participate in CAP and who will not be paid for the drugs obtained from the approved CAP vendor.

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Additionally, unless claims for CAP administration do not include the CAP drug no-pay, restocking, or “furnish as written” modifier, the claim will be denied and you will see a remittance advice, N348, stating that “You chose that this service/supply/drug be rendered/supplied and billed by a different practitioner/supplier.”

**Note:** The physician’s local carrier will monitor drugs that are:

- Obtained using the “furnish as written” provision to ensure that the participating CAP physician is complying with Medicare payment rules; and
- Ordered under the replacement provision to ensure that the participating CAP physician is complying with Medicare payment rules.

### **Vendor Billing**

The approved CAP vendor will bill the:

- Medicare designated carrier for the drug; and
- Beneficiary for any applicable coinsurance and deductible.

The approved CAP vendor will also include a prescription/order number on the claim to identify each CAP drug administered.

**Note:** Payment to the approved CAP vendor for the drug is conditioned on verification that the drug was administered to the Medicare beneficiary.

Proof that the drug was administered shall be established by matching the participating CAP physician’s claim for drug administration with the approved CAP vendor’s claim for the drug in the Medicare claims processing system by means of a prescription number on both claims. When they are matched in the claims processing system, the approved CAP vendor will be paid in full. Until drug administration is verified, the approved CAP vendor may not bill the beneficiary and/or his third party insurance for any applicable coinsurance and deductible.

Participating CAP physicians must appeal drug administration denials. For a nonparticipating physician that elects to participate in the CAP, he or she must agree to accept assignment for all CAP drug administration charges to allow for the Medicare beneficiary’s and approved CAP vendor’s appeal rights. Carriers shall pay all HCPCS codes that provide payment for the administration of CAP drugs on an assigned basis.

### **Implementation**

The implementation date for this instruction is July 3, 2006.

### **Additional Information**

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to CMS’ Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R777CP.pdf>. Also, additional information on the CAP program is available on CMS’ Web site at <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>.

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

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# Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs & Biologicals

**Note:** This article was revised on May 8, 2006, to show that the 2006 election period runs from May 8, 2006, to June 2, 2006.

## Impact to You

This article is based on Change Request (CR) 4309, which provides additional requirement for the CAP for Part B drugs and biologicals.

## What You Need to Know

CR 4309 provides additional instructions for the implementation of the CAP program. It builds on CR 4064 through business requirements that were identified through the implementation process of CR 4064 and the development of the final CAP rule published on November 21, 2005.

## What You Need to Do

See the *Background* section of this article for further details regarding these additional requirements.

## Background

Change Request (CR) 4309 provides new requirements that were identified both during the coding process of CR 4064 (<http://new.cms.hhs.gov/transmittals/downloads/R777CP.pdf>) and the publication of the final rule for the CAP for Medicare Part B drugs. It provides additional instructions for the implementation of the CAP program as outlined in CR 4064, and it is tied to the business requirements in CR 4064. CR 4309 is not a stand-alone CR and needs to be understood in conjunction with CR 4064.

## The Competitive Acquisition Program (CAP) for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis

The Medicare Prescription Improvement and Modernization Act of 2003 (MMA's, Section 303 (d), requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system (PPS) basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. For a complete overview of the program, see the MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>.

**Note:** For 2006, the first CAP year will run from July 1, 2006, through December 31, 2006. In subsequent years, it will run annually on a calendar year basis.

MMA, Section 303 (d) may be found at <http://www.cms.hhs.gov/MMAUpdate/>. Social Security Act, Section 1861(s) is available at [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm).

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The Centers for Medicare & Medicaid Services (CMS) may exclude drugs from the CAP if competitive pricing will not result in significant savings, or is likely to have an adverse impact on access to such drugs.

**Note:** Physicians will still be able to continue to purchase and bill Medicare under the Average Sales Price (ASP) system for those drugs provided by physicians who selected that vendor;

- Every claim from a vendor will indicate that all appeals on CAP claims must be adjudicated by the physician's carrier;
- Members of a group must elect to participate in the CAP as a whole group when billing as a group;
- Only members of a group who have prescriptive authority are eligible to participate in the CAP;
- Any carrier that is currently applying a local billing policy for unused drug (waste) that requires a separate detail line with the unused drug HCPCS modifier (JW) may continue to apply that policy under the CAP, but they must require the addition of the CAP modifier to the line;
- Claims that include the no-pay, restocking, or furnished as written modifier (as noted in CR 4064) will be treated as unprocessable if they contain one of the following invalid HCPCS modifier combinations:
  - J1 and J3
  - J2 without J1
  - J2 and J3
- The J1 HCPCS modifier must be on every physician claim for a CAP drug;
- Vendors may petition CMS to add new drugs to their vendor specific drug list on a quarterly basis;
- The UPIN (or NPI) of the ordering physician must be entered on every vendor claim and match the UPIN (or NPI) of a physician that has elected that vendor; and
- All HCPCS codes for the administration of CAP drugs must be billed as assigned.

When physicians or practitioners submit a paper claim with a no-pay modifier on a line, but without a prescription number on that line, the claim will be rejected and returned with remittance advice remark code MA130, indicating "Your claim contains incomplete information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

### **Implementation**

The implementation date for this instruction is July 3, 2006, except where otherwise indicated in this article.

### **Additional Information**

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R866CP.pdf>. In addition, you may wish to review CR 4064 at <http://www.cms.hhs.gov/Transmittals/downloads/R777CP.pdf> and its related article at <http://www.cms.hhs.gov/MLNMArticles/downloads/MM4064.pdf>.

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

# Physician Election for Competitive Acquisition Program (CAP) Drugs

## Provider Action Needed

This article is based on Change Request (CR) 4404, which provides instruction for physicians who wish to elect the CAP to obtain certain Medicare Part B drugs and biologicals.

## What You Need to Know

Physicians will be given an opportunity to elect to participate in the CAP on an annual basis, and practitioners who elect to participate in the CAP will be required to remain in the program at least one calendar year except under certain circumstances.

Physicians who elect to participate in the CAP will be required to complete a CAP election agreement. In 2006, the election period will occur from May 8, 2006, to June 2, 2006, and the term of election will run from July 1 to December 31, 2006.

## Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d) <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or Prospective Payment System (PPS) basis.

Beginning with drugs administered **on or after July 1, 2006**, physicians will be given a choice between:

- Buying and billing these drugs under the average sales price (ASP) system; or
- Obtaining these drugs from CAP vendors selected in a competitive bidding process.
  - For 2006 the CAP approved vendor is Bioscrip, Vendor Identification Number Q103. [http://www.cms.hhs.gov/CompetitiveAcquisforBios/15\\_Aproved\\_Vendor.asp#TopOfPage](http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Aproved_Vendor.asp#TopOfPage)

**Note:** For purposes of the CAP, a physician includes individuals defined under the Social Security Act (Section 1861(r); [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)) and other practitioners who are authorized to provide physician services under 1861(s) and who can, within their state's scope of practice, prescribe and order drugs covered under Medicare Part B.

This article is based on Change Request (CR) 4404, which in addition to including the final physician election agreement included as an attachment, provides information and instructions for the implementation of the CAP pertaining to the physician election process as outlined in:

- CR 4064 (Transmittal 777, dated December 9, 2005; <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>); and
- CR 4309 (Transmittal 839, dated February 6, 2006; <http://www.cms.hhs.gov/transmittals/downloads/R839CP.pdf>)

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- The MLN Matters article corresponding to CR 4064 can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>; and the article corresponding to CR 4309 can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>.

In order to implement the annual physician election process, the Centers for Medicare & Medicaid Services (CMS) instructed your carrier in CR 4064 to:

- Accept physician election applications immediately following the posting of approved CAP vendors on the CMS Web site;
- Create an initial list of all the physicians and practitioners **who have elected to participate** in CAP;
- Forward this information to the designated CAP vendor carrier Noridian; and
- Repeat this process annually.

### **Annual Physician Election Process**

Physicians will be given an opportunity to elect to participate in the CAP on an annual basis, and practitioners who elect to participate in the CAP will be required to remain in the program at least one calendar year. The CAP physician election form is included with CR 4404 and can be found online at [http://www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp#TopOfPage](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage)

Participating physicians who wish to continue their participation in CAP for subsequent years would do so by submitting an abbreviated agreement, which would also permit the practitioners to change approved CAP vendor or CAP drug category.

### **CAP Participating Physician Requirements**

Physicians who elect to participate in the CAP will be required to complete a CAP election agreement (final attached to CR 4404) assuring full and continued compliance with the participating CAP physician requirements per Title 42 CFR (Code of Federal Regulations) Part 414 Section 908 (<http://www.gpoaccess.gov/cfr/retrieve.html>) of Medicare regulations.

If a physician makes the decision to participate in the CAP, payment for the administration of any CAP drug or biological may be made only on an assignment related basis. Additional details are available in the *Medicare Claims Processing Manual*, Chapter 17, Sections 100-100.8.2, which are included in Attachment A of CR 4404.

### **Application Process**

Physicians who would like to participate in the program can obtain the following information at [http://www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp):

- The CAP physician election form;
- The list of the approved CAP vendors; and
- The specific National Drug Codes (NDCs) that the vendors will provide.

Once the election agreement is completed, it must be submitted to the practitioner's local Medicare carrier.

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**The physician election process for 2006 shall operate from May 8 to June 2. For subsequent calendar years, CMS anticipates that the physician election process will be between October 4 and November 15 of each calendar year** to meet operational timeframes for CAP vendors and claim processing contractors.

**Note:** The CAP election agreement must be postmarked by June 2 for 2006, election period. The 2006 CAP operational period will be for July 1- December 31, 2006.

### **Group Election**

When a member in a group practice bill Medicare using the group's PIN, they must commit as a group practice to elect to participate in the CAP.

In order for a physician to "buy and bill" separately from the group he or she must not have reassigned his or her benefits to the group, and must be billing using his or her individual PIN.

If a physician in that situation elects to participate in the CAP as an individual, he or she would complete the CAP physician election form with his or her individual PIN, and other requested information.

### **Mid-Year Changes**

Physicians are permitted to select another approved CAP vendor or leave the CAP in mid-year if any one of the following occur:

- The approved CAP vendor selected by the physician leaves the program;
- The participating physician leaves a group practice, or a new physician enters a group practice that had selected the approved CAP vendor;
- The participating physician relocates to another competitive acquisition area (Although multiple CAP competitive areas are anticipated, there is one drug category and one geographic area for the 2006 through 2008 contract period.);
- The physician is newly enrolled in the Medicare program and elects to participate in the CAP within 90 days of enrollment; or
- The approved CAP vendor refuses to ship to the participating CAP physician because the conditions of 42 CFR § 414.914(h) were met, the physician may withdraw from the CAP category for the remainder of the year upon notice to CMS and the approved CAP vendor.

### **CAP Physician Election Agreement**

The final CAP physician election agreement is included as an Attachment to CR 4404. Providers interested in participating in the CAP must download the form from the CAP Web site and complete pages 1, 5, and 6 of the agreement. If a physician has more than one practice location additional copies of page 6 must be submitted. For group practices all physician members who will be participating in the CAP and billing under the group PIN must be listed, however only one election agreement should be submitted for each group practice. An authorized representative must sign the form on behalf of the individual or group practice members on page 5. The authorized official must be the provider's general partner, chairman of the board,

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chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider or must hold a position of similar status or authority within the provider's organization.

In summary, CR 4404 instructs your carrier to receive the CAP physician election agreement forms submitted by physicians who wish to participate in the CAP in their area either during the annual election process or because of a mid-year change.

Please note that:

- Claims submitted by a physician for CAP drugs with a date of service after the effective date the physician disenrolled from the CAP will be processed as ASP claims.
- Claims submitted by the vendor for CAP drugs with a date of service prior to the effective date the physician disenrolled from the CAP will be processed as CAP claims.

### **Implementation**

The implementation date for this instruction is May 30, 2006.

### **Additional Information**

Attached to CR 4404 is the Competitive Acquisition Program (CAP) Physical Election Agreement for Medicare Part B Drugs. For complete details, please see CR 4044 at <http://www.cms.hhs.gov/Transmittals/downloads/R932CP.pdf>.

The list of CAP drugs can be found at [http://www.cms.hhs.gov/CompetitiveAcquisforBios/15\\_Approved\\_Vendor.asp#TopOfPage](http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage)

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

# Medicare Remit Easy Print (MREP) Update

## Provider Action Needed

This article is based on Change Request (CR) 5032 which advises providers to use Medicare Remit Easy Print (MREP) software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (RA) for accounts reconciliation and crossover claims submission to secondary/tertiary payers.

## What You Need to Know

CR 5032 also includes instructions for Medicare's system maintainer (VIPS) to update MREP software with additional functionalities, and directs carriers and DMERCs to test and communicate to the end users about the software update.

## What You Need to Do

See the *Background* section of this article for further details regarding this update.

## Background

The Centers for Medicare & Medicaid Services (CMS) developed Medicare Remit Easy Print (MREP) software as a tool providers can use to read and print an electronic remittance advice (RA) in a human readable format. The format is based on the current Standard Paper Remittance (SPR) format. Providers who use the MREP software package can:

- Print paper documentation that can be used to reconcile accounts receivable; and
- Create document(s) that can be included with claim submissions to Coordination of Benefits (COB) payers.

The MREP software became available on October 11, 2005, to providers (Part B and DMERC) through their respective Medicare carrier/DMERC, and it was updated this year in April and July.

CR 5032 further encourages providers to use the MREP software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic RA for accounts reconciliation and crossover claims submissions to secondary/tertiary payers.

CMS created a process to receive suggestions from providers, Medicare Contractors, and CMS staff in order to continuously improve and enhance MREP's functionality and effectiveness. A summary listing of the improvements to be implemented in the October 2006, update of MREP is included in the *Additional Information* section of this article.

**Note:** This update to MREP software includes suggestions for improvements received before the cut off date of March 15, 2006.

Beginning June 1, 2006, Medicare contractors and DMERCs (and later DMACs) will start suppressing the issuance of standard paper remittance advices (SPRs) to providers/suppliers, billing agents, clearing houses, or other entities representing providers, who also have been receiving electronic remittance advice

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(ERA) transactions for 45 days or more. MREP is an option for providers to print their own remittances at their own computer.

After the October 2006 update, annual updates of MREP will be provided every October unless a critical error affecting production needs to be corrected. The software will also be updated three times a year to implement the Claim Adjustment Reason and Remittance Advice Remark code changes. See Special Edition MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf> for options for providers affected by this change.

### **Implementation**

The implementation date for CR 5032 is October 2, 2006. Your carrier/DMERC will post a notice to their web site on or after October 2, 2006, to alert you that the new version of the MREP software is available for download and that the software includes the latest version of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes.

### **Additional Information**

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R927CP.pdf>.

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

### **List of Improvements to be Implemented in October 2006**

<b>Synopsis of Change</b>
A provider would like to have the Provider ID added after the Payee Name. This way, when they have multiple providers and provider locations, they can sort them easier. The Provider ID will be displayed after the Payee Name on the MREP Main Page.
New report/listing of accounts NOT FORWARDED to supplemental or crossovers.
A new report is added to show "Late Filing."
A new report will be created showing only those items with coinsurance.
Print reason/remark codes on same page as Remittance; or, can there be a check box that will either print the codes or not? The MREP software is being changed to include a check box to allow the user to have the remit print with or without the reason/remark codes.
The program should automatically import the 835 file. CMS is looking into this possibility or identifying and displaying the 835 file and path.
Searchable "Help" menu and Index. The analysis is underway to determine the appropriate level of a help facility.

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# Suppression of Standard Paper Remittance Advice (SPR) to Providers & Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More: Options

## Provider Action Needed

This Special Edition reminds providers that as of June 1, 2006, if you have been receiving **both** an Electronic Remittance Advice (ERA), either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a Standard Paper Remittance (SPR) from your carrier/DMERC for 45 days or more, that **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376. This article outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC.

## What You Need to Know

Are you receiving an ERA? Make sure you know if and how you receive the ERA. You may be receiving your ERA directly from your carrier/DMERC or you may be receiving your ERA indirectly through a billing agent, clearinghouse, or other entity representing you. No matter how you receive your ERA, if you are also receiving an SPR from your carrier/DMERC in addition to receiving an ERA for 45 days or more, after June 1, 2006, your carrier/DMERC will no longer mail you an SPR. **If you still need both, take appropriate action now.**

## What You Need to Do

If you need the SPR, take action **NOW** so you can avoid any business disruption associated with the June 1, 2006, cutoff of the SPR. If your clearinghouse, billing agent, or other entity cannot offer a way (e.g., print software) for you to receive or generate a paper remittance, it may be beneficial to explore other options.

## Determine which of the following scenarios represents your situation:

- 1. You are receiving the ERA directly from your carrier in the HIPAA-compliant 835 format:** Use the Medicare Remit Easy Print (MREP) software. <sup>1</sup> MREP requires that you import ERAs in the HIPAA-compliant 835 format. (See the *Additional Information* section of this article for further information.) MREP is **free** software that allows you to:
  - Print the ERA for individual or multiple selected claims in a format mirroring the SPR, so you can forward your remittance to secondary/tertiary payers;
  - Easily navigate and view remittance information;
  - Quickly access claim information;
  - Print and export useful reports about ERAs including denied, adjusted, and deductible service lines;
  - Receive the latest version of Claim Adjustment Reason and Remittance Advice Remark Code sets, three times a year;
  - Archive, restore, and delete imported ERAs; and
  - Eliminate physical filing and storage space needs.

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2. **You are receiving a HIPAA-compliant 835 from a billing agent, clearinghouse, or other entity:** Use MREP or software offered by the billing agent, clearinghouse, or other entity representing you to view and print your paper remittance advice.
3. **You are receiving the ERA directly in a format that is not the HIPAA-compliant 835 format:** Transition to the HIPAA-compliant 835 format now, so you can begin using MREP. CMS ended the contingency plan for non-HIPAA claims, i.e., 837 transaction, in 2005. CMS will be ending the contingency plan for the non-HIPAA remittance advice, i.e., the 835, next.
4. **You are receiving an ERA that is not the HIPAA-compliant 835 format from your billing agent, clearinghouse, or other entity representing you and they do not offer software or other means that allows you to view and print your remittance advice:** Work with them so that they will send you a HIPAA-compliant 835, so you can use MREP.
5. **You have a need for the paper remittance advice and your clearinghouse, billing agent, or other entity representing you is receiving the ERA on your behalf, but does not currently forward the ERA to you:** Work with your clearinghouse, billing agent, or other entity to receive the ERA and use MREP. This may be your situation if the clearinghouse, billing agent, or other entity representing you receives the ERA for you, but until now there has been no business reason to forward the ERA to you.

### **Background**

CMS has an initiative for moving to a more electronic transaction environment and reducing the cost associated with producing and mailing the paper remittances sent by CMS contractors. The *Medicare Claims Processing Manual*, Chapter 22, Section 40.1, Remittance Advice, describes the instructions issued by CMS to carriers and DMERCs. The section instructs carriers and DMERCs to eliminate SPRs to those providers/suppliers who were receiving ERA transactions for 45 days or more.

### **Implementation**

The implementation date is June 1, 2006

### **Additional Information**

To learn about more MREP benefits, download the brochure available at [http://www.cms.hhs.gov/MLNProducts/downloads/remit\\_easy\\_print.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf).

Or, you can view Special Edition MLN Matters article SE 0611 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf> or a related MLN Matters article (MM 4376) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf>.

The official instructions (CR 4376) issued to your carrier/DMERC regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R885CP.pdf>.

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If you have any questions, please contact the Electronic Data Interchange Toll-Free number at 1-866-308-5438.

<sup>1</sup> This software was developed by the Centers for Medicare & Medicaid Services (CMS) for use by Medicare providers/suppliers to view and print a Health Insurance Portability and Accountability (HIPAA)-compliant Medicare 835. Medicare has no liability and takes no responsibility for any other use of this software.

## **Submission of CLIA & FDA Numbers Attention Electronic Biller**

Electronic claims submitted with the mammography certification number at the claim level (2300/REF/EW, 02) and a CLIA number at the service line level (2400/REF/X4, 02), or vice versa, will only map the claim level information. This could result in a rejection of the service if the mapped claim level information does not correspond with the service rendered.

If both the mammography certification and CLIA numbers are required on the same claim, service line level information must be submitted. For the mammography certification number, submit the information in 2400/REF/EW, 02) and the CLIA number in 2400/REF/X4,02. If submitted inappropriately, the service(s) may be rejected.

# 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule - July Quarterly Update

## Providers Action Needed

This article is based on Change Request (CR) 5017 and provides specific information regarding the quarterly update for the July 2006 DMEPOS Fee Schedule.

## Background

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

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

Payment on a fee schedule basis is required for:

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

## Changes Made in the Update

Changes made in this update include the following:

The fee schedule amounts for the following HCPCS codes are added to the fee schedule file as part of this update and are effective for claims with dates of service on or after January 1, 2006:

L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L5703, L5858, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405, E1238, E1812, E2291, E2292, E2293, E2294

The fee schedule amounts for HCPCS code **K0733**, *Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)* are added to the fee schedule file on July 1, 2006, and is effective for claims with dates of service on or after July 1, 2006.

The fee schedule amounts for HCPCS code **E0762**, *Transcutaneous electrical joint stimulation device system, includes all accessories*, are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006. In addition, the payment category for HCPCS code **E0762** is being revised to move the joint stimulation device from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective July 1, 2006.

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The fee schedule amounts for HCPCS codes **L6694** and **L6698** are added to the fee schedule file on July 1, 2006, and are effective for claims with dates of service on or after January 1, 2005.

The fee schedules for HCPCS code **L2232**, *Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only*, are added to the fee schedule file on July 1, 2006, and are effective for claims with dates of service on or after January 1, 2005.

**HCPCS code E0705** (Transfer Board or Device, Any Type, Each) was added to the HCPCS effective January 1, 2006. The payment category for HCPCS code E0705 is being revised to the inexpensive and routinely purchased payment category and the fee schedule amounts for previous HCPCS code E0972 will be cross walked to HCPCS code E0705 for use in paying claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code **K0606** (Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type) are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

The fee schedule amounts for HCPCS code **E1812** (Dynamic Knee, Extension/Flexion Device with Active Resistance Control) are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

As part of this update, the common working file category for HCPCS code **B4185** will be switched from CWF category 9 to CWF category 20, effective January 1, 2006. HCPCS code B4185 was added to the HCPCS on January 1, 2006, to replace HCPCS codes B4184 and B4186 and describes parenteral nutrients (CWF category 20) as opposed to enteral nutrients (CSF category 9).

Per CR 4267, the following four adjustable wheelchair cushions HCPCS codes are added to the HCPCS, effective July 1, 2006:

- K0734 - Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth
- K0735 - Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth
- K0736 - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 Inches, Any Depth.
- K0737 - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth. (See the MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4267.pdf>.)

The fee schedule amounts for the above HCPCS codes, K0734, K0735, K0736, and K0737, are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

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HCPCS codes A6531 and A6532 were added to the HCPCS January 1, 2006, to replace HCPCS codes L8110 and L8120; therefore, all billing and payment requirements for HCPCS codes L8110 and L8120 crosswalk directly to HCPCS codes A6531 and A6532, including the requirement to bill HCPCS modifier AW when items are furnished for use as surgical dressings (see transmittal AB-03-100).

### **Implementation**

The implementation date for the instruction is July 3, 2006.

### **Additional Information**

The official instructions issued to your intermediary, carrier, or DMERC regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R928CP.pdf>.

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

## **Interest Payment on Clean Claims Not Paid Timely**

This rate is determined by the Treasury Department on a 6-month basis, effective every January 1 and July 1. For the correct rate, providers may access the Treasury Department Web page at <http://www.publicdebt.treas.gov/opd/opdprmt2.htm>.

## Free Evaluation & Management Medicare Part B Seminars

Palmetto GBA is presenting **FREE Evaluation & Management Seminars** in Ohio and West Virginia 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, June 7, 2006	Double Tree Cleveland South 6200 Quarry Lane Independence, Ohio 44131	10:00 a.m. - 12:00 p.m. & 1:00 p.m. - 3:00 p.m.

### West Virginia Seminars

Date	Location	Time
Wednesday, June 21, 2006	Mountaineer Conference Center 2124 Harper Road Beckley, WV 25801	10:00 a.m. - 12:00 p.m.
Tuesday, June 27, 2006	Clarion Hotel and Conference Center 233 Lowe Drive Shepherdstown, WV 25443	8:30 a.m. - 12:00 p.m.
Tuesday, June 27, 2006	Clarion Hotel and Conference Center 233 Lowe Drive Shepherdstown, WV 25443	1:00 p.m. - 4:30 p.m.

### Registration:

To Register for a seminar please go to:

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

You will need to login with your username and password to register. In order to register for a seminar, you must first create a username and password. For additional questions please call 1-877-567-9232 option 7, then option 4.

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# Preventive Services & Screenings & Medicare Coverage

## Provider Action Needed

This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

## Introduction

Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This Special Edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services.

## Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Adult Immunizations
  - o Influenza (Flu)
  - o Pneumococcal Polysaccharide Vaccine (PPV)
  - o Hepatitis B Virus (HBV)
- Bone Mass Measurements
- Cancer Screenings
  - o Breast (Mammography)
  - o Cervical & Vaginal (Pap Test & Pelvic Exam)
  - o Colorectal
  - o Prostate
- Cardiovascular Disease Screening
- Diabetes Screening, and
  - o Self-Management Training
  - o Medical Nutrition Therapy
  - o Supplies
- Glaucoma Screening
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Service

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CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

### **Educational Products and Informational Resources for Health Care Professionals**

CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare's coverage of disease prevention and early detection;
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible; and
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

### **Product Ordering Instructions**

To order a product, free of charge, go to [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5), Order Product.

### **Brochures**

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of tri-fold brochures provides an overview of Medicare's coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See *Expanded Benefits* brochure)

- **Adult Immunizations [PDF 279KB]:** [http://www.cms.hhs.gov/MLNProducts/downloads/adult\\_immunization\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization_06-08-05.pdf)
- **Bone Mass Measurements [PDF 269KB]:** [http://www.cms.hhs.gov/MLNProducts/downloads/bone\\_mass\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.pdf)
- **Cancer Screenings [PDF 295KB]:** [http://www.cms.hhs.gov/MLNProducts/downloads/cancer\\_screening\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening_06-08-05.pdf)
- **Expanded Benefits [PDF 255KB]:** [http://www.cms.hhs.gov/MLNProducts/downloads/expanded\\_benefits\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits_06-08-05.pdf)
- **Glaucoma Screening [PDF 242KB]:** [http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma_06-08-05.pdf)

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- **Smoking and Tobacco-Use Cessation Counseling Services [PDF, 562KB]** (available in download only at this time): <http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf>

## **Guides**

***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals [PDF 2MB]*** - This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005; See the Errata Sheet for corrections identified since May 2005 printing.) [http://www.cms.hhs.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf)

***Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services [PDF 304KB]*** - This guide provides information on interpreting the Medicare beneficiary preventive services "next eligible date" data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access Common Working File (CWF) records. (September 2005; Available in download only) [http://www.cms.hhs.gov/MLNProducts/downloads/Preventive\\_Services\\_Eligibility.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Preventive_Services_Eligibility.pdf)

## **Medicare Preventive Services CD-ROM**

***Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals*** - This CD-ROM contains *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*; six brochures:

- 1) *Expanded Benefits*,
- 2) *Glaucoma Screenings*,
- 3) *Cancer Screenings*,
- 4) *Bone Mass Measurements*,
- 5) *Adult Immunizations*, and
- 6) *Smoking and Tobacco-Use Cessation Counseling Services*; and a *Quick Reference Information: Medicare Preventive Services* chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. (See Errata Sheets for corrections identified since May 2005 printing of these products; See product ordering instructions above.)

## **Quick Reference Information Chart**

***Quick Reference Information: Medicare Preventive Services [PDF 74KB]*** - This two-sided laminated chart gives a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (May 2005; See Errata Sheet for corrections identified since May 2005 printing.) [http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_prevent\\_serv.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_prevent_serv.pdf)

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### **Video Programs**

**Flu Billing Made Easy** - This video explains the process of billing for flu and pneumonia vaccinations. (January 2004) (English and Spanish) Ordering and other relevant information can be found at the following Web pages:

- **Flu Billing Made Easier – Order** (English and Spanish video): [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5)
- **Flu Billing Made Easier – Video Transcript [PDF 91KB]**: <http://www.cms.hhs.gov/MLNProducts/Downloads/FluBillingMadeEasierTranscriptNOV05.pdf>
- **Flu Billing Made Easier – Video Errata [PDF 13KB]**: <http://www.cms.hhs.gov/MLNProducts/downloads/ErrataFluBillingNOV05.pdf>
- **Flu Billing Made Easier Recommended Dial-Up**: <http://media.cms.hhs.gov/cms/cms%20flu%20billing%20wm9%20100%20cbr.wmv>
- **Flu Billing Made Easier Recommended DSL/Cable**: <http://media.cms.hhs.gov/cms/cms%20flu%20billing%20wm9%20300%20cbr.wmv>
- **Flu Billing Made Easier Recommended T1/DS3**: <http://media.cms.hhs.gov/cms/cms%20flu%20billing%20wm9%20700%20vbr.wmv>

### **Web-Based Training Courses**

**Web-Based Training Modules (WBTs)** - Three Web-based training courses covering coding, billing, coverage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products Web page at <http://www.cms.hhs.gov/MLNProducts/>, scroll to the bottom of the page to “Links Inside CMS” and click on Web-based Training Modules.

### **Web Page**

**MLN Preventive Services Web Page** - This Medicare Learning Network (MLN) Web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article. [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)

### **Other Useful Provider Resources**

Other useful provider resources include the following:

- **Prevention Toolkit** - This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits. [http://www.cms.hhs.gov/PrevntionGenInfo/01\\_overview.asp](http://www.cms.hhs.gov/PrevntionGenInfo/01_overview.asp)
- **Immunizations Toolkit** - This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers. <http://www.medqic.org/dcs/ContentServer?pagename=Medqic/Content/ParentShellTemplate&parentName=Setting&c=MQParents&cid=1089815966986>

### **CMS Prevention Web Pages**

CMS has created individual Web pages for each of the preventive services and screenings covered by Medicare. For additional information visit <http://www.cms.hhs.gov/home/medicare.asp> and scroll down to the Prevention section.

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### **Medicare Learning Network (MLN)**

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's Web page at <http://www.cms.hhs.gov/MLNGenInfo>.

We encourage you to order and use these provider-specific products to:

- Increase your awareness of preventive services covered by Medicare;
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits; and
- Help you file preventive services claims more effectively.

**Please Note:** These products have been developed for you, the health care professional. Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

### **Preventive Benefit Information for Medicare Beneficiaries**

Medicare beneficiaries can obtain information about Medicare preventive benefits by going to <http://www.medicare.gov/> and clicking on "Preventive Services." They can also call 1-800- MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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# Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of CPT Code 90660 (Reporting of the Influenza Virus Vaccine & Diagnosis Code V06.6)

## Providers Action Needed

This article and Change Request (CR) 5037 provides specific information regarding payment for Influenza and/or PPV vaccines and their administration. Effective for dates of service on or after October 1, 2006, the following are the new instructions:

- **Report diagnosis code V06.6** on claims that contain Influenza Virus and/or PPV vaccines and their administration when the purpose of the visit was to **receive both** vaccines.
- Continue reporting **diagnosis code V03.82** on **claims that contain only PPV vaccine** and its administration.
- Continue reporting **diagnosis code V04.81** on **claims that contain only Influenza Virus** vaccine and its administration.
- Use **CPT code 90660** on claims when **billing for** Influenza Virus vaccine, live, for Intranasal use.
- Neither a deductible nor a coinsurance will be applied to Influenza Virus vaccine, CPT code 90660, and its administration.
- Use **HCPCS code G0008** when billing for the **administration of CPT code 90660**.

## Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding payment for Influenza and/or PPV vaccines and its administration. Currently, providers are required to report diagnosis codes V03.82 for PPV and its administration and diagnosis code V04.81 for Influenza Virus vaccine and its administration. This instruction allows the reporting of diagnosis code V06.6 in place of V03.82 and V04.81 when reporting Influenza Virus and/or PPV vaccines when the purpose of the visit was to receive both vaccines. In addition, this instruction requires Medicare carriers/FIs to accept claims containing CPT code 90660 for the Influenza Virus vaccine.

## Implementation

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

## Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R921CP.pdf>.

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

# Ambulatory Surgical Center (ASC) Claims Processing Manual Clarification

## Provider Action Needed

This article is for informational purposes. CR 5026 revises the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) to clarify policy regarding the provision, coverage, and payment of services furnished in an ASC.

## Background

Medicare conventionally reimburses ASCs in the form of a single payment that includes all “facility services” that the ASC furnishes in connection with a covered procedure. However, an ASC (perhaps as part of a medical complex that may include other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician’s office) may also furnish a number of covered items and services that are not considered facility services.

You should be aware that such entities, which are separate from the ASC, are covered separately under Part B. Further, in general, the items or services that these entities provide are not considered ASC services, and are therefore not included in the ASC payment, but are rather covered and paid for under the applicable Part B provisions.

Examples of such services include:

- Physicians’ services;
- Durable medical equipment (DME);
- Implantable DME;
- Prosthetic devices;
- Ambulance services;
- Leg, arm, back and neck braces;
- Artificial legs, arms and eyes; and
- Services of an independent laboratory.

More detail about each of these services can be seen in Table 1, on the next page.

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**Table 1: Examples of Services Not Included in the ASC Facility Rate**

Items or Services	Who Receives Payment	Submit Bills To
<p><b>Physicians’ services</b></p> <p>Physicians who perform covered services in ASCs receive separate payment under Part B. Such services include:</p> <p>Anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients’ recovery from the anesthesia;</p> <p>Routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, suture removal, dressing changes, and other services which are usually included in the physician fee for a given surgical procedure.</p>	Physician	Carrier
<p><b>Non-implantable durable medical equipment (DME) to ASC patients for in-home use.</b></p> <p>ASCs who sell, lease, or rent items of DME to patients, are treated as DME suppliers.</p> <p>All of the ordinary DME-appliance rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p> <p>An ASC can be a supplier of DME if it has a DME Supplier number from the National Supplier Clearinghouse.</p>	DMERC
<p><b>Implantable DME &amp; accessories</b></p> <p>ASCs who furnish implantable DME items to patients, bill the local carrier for the surgical procedure and the implantable device.</p>	ASC	Carrier

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Items or Services	Who Receives Payment	Submit Bills To
<p><b>Non-implantable prosthetic devices</b></p> <p>ASCs who furnish non-implantable prosthetic devices to patients, are treated as suppliers, and all the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p> <p>An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.</p>	<p>DMERC</p>
<p><b>Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs [new technology intraocular lenses]), and accessories</b></p> <p>ASCs may bill and receive separate payment for prosthetic devices (other than intraocular lenses [IOLs]) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule.</p> <p>An intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate. ASCs may receive additional payment for approved NTIOLs that are furnished in an ASC during or subsequent to certain cataract procedures. ASC Carrier</p>	<p>ASC</p>	<p>Carrier</p>
<p><b>Ambulance services</b></p> <p>ASCs who furnish ambulance services, may obtain approval as ambulance suppliers to bill covered ambulance services</p>	<p>Certified ambulance supplier</p>	<p>Carrier</p>

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Items or Services	Who Receives Payment	Submit Bills To
<p><b>Leg, arm, back, and neck braces</b></p> <p>These items of equipment are not included in the ASC facility payment amount, but are covered under Part B.</p> <p>ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to apply to the ASC, including obtaining a supplier number and billing the DMERC as required. Supplier DMERC</p>	Supplier	DMERC
<p><b>Artificial legs, arms, and eyes</b></p> <p>These items of equipment are not included in the ASC facility payment rate, but are covered under Part B.</p> <p>ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to suppliers apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier	DMERC

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Items or Services	Who Receives Payment	Submit Bills To
<p><b>Services furnished by an independent laboratory</b></p> <p>Only very limited numbers, and types, of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate.</p> <p>Since coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals is limited to facilities that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests performed directly by an ASC are not considered ASC facility services (in fact are usually not covered under Medicare).</p> <p>ASC laboratories must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services.</p> <p>If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.</p>	<p>Certified lab. ASCs can receive lab certification and a CLIA number.</p>	<p>Carrier</p>
<p><b>Procedures NOT on the ASC list</b></p> <p>Physicians bill the carrier for the procedures and any implantable prosthetics/DME, using the ASC as the place of service</p>	<p>Physician</p>	<p>Carrier</p>

**Additional Information**

You can find more information about services not included in the ASC facility rate (and the coverage of such services) by reviewing CR 5026, which is available on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R942CP.pdf>.

The revised *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) are attached to CR 5026.

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

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# Additional \$50 Payment for New Technology Intraocular Lenses (NTIOLs) Furnished in Ambulatory Surgical Centers (ASCs)

## Impact to You

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay you an additional \$50 for NTIOL Category 3 (Reduced Spherical Aberration); Advanced Medical Optics (AMO) Tecnis® IOL model numbers Z9000, Z9001, and ZA9003.

## What You Need to Know

Your carrier will pay you an additional \$50 for the insertion of NTIOL Category 3; Advanced Medical Optics (AMO) Tecnis® IOL, model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). In addition, any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period. Effective for all NTIOL Category 3 claims with dates of service on and after February 27, 2006, through February 27, 2011, Medicare-approved ASCs are eligible for the additional \$50 when billed using HCPCS code Q1003 along with CPT codes 66982, 66983, 66984, 66985, or 66986.

## What You Need to Do

Make sure that your billing staff are aware of this additional NTIOL payment and the required HCPCS code Q1003.

## Background

Section 141(b) of the Social Security Act Amendments of 1994 (SSAA 1994) requires that CMS establish a process for designating particular IOLs as “new technology,” and therefore eligible for additional payment. A final rule, published in the Federal Register (FR) on June 16, 1999 (64 FR 32198), established: (1) the process for adjusting payment amounts for NTIOLs that ASCs furnish; (2) an initial flat rate payment adjustment of \$50; and, (3) a 5-year payment adjustment period beginning when CMS recognizes the first of a new IOL subset or class.

CR 4361, from which this article is taken, announces the approval of NTIOL Category 3 (as defined in the FR at 71 FR 4586, dated January 27, 2006) which applies to Advanced Medical Optics (AMO); Tecnis® IOL model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). Additionally, any subsequent IOLs having the same characteristics as the first IOL recognized for payment will receive the same adjustment for the remainder of the 5-year period. This category and the associated \$50 NTIOL Medicare payment adjustment will expire on February 26, 2011.

The payment adjustment is allowed when Medicare-approved ASCs (place of service 24) insert a Category 3 NTIOLs and submit HCPCS code Q1003 (created for this purpose) on the same claim as the surgical insertion procedure (CPT codes 66982, 66983, 66984, 66985, or 66986). HCPCS code Q1003 is already

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established and listed in the HCPCS file, and the Medicare Claims Processing Manual, chapter 14, Sections 10.2 & 40.3, have been updated to reflect this change. procedure (CPT codes 66982, 66983, 66984, 66985, or 66986). HCPCS code Q1003 is already established and listed in the HCPCS file, and the *Medicare Claims Processing Manual*, Chapter 14, Sections 10.2 & 40.3, has been updated to reflect this change.

Please be aware that carriers will deny payment for HCPCS code Q1003 when submitted by ASCs not approved by Medicare. If denied, the carrier will use appropriate messages such as MSN# 16.2 (This service cannot be paid when provided in this location/facility) and Claims Adjustment Reason Code #58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service).

Carriers will return as unprocessable claims for NTIOLs with HCPCS code Q1003 alone or with a CPT code other than 66982, 66983, 66984, 66985, or 66986. When such claims are returned, claim adjustment reason code 16 (Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice codes whenever appropriate) will be used. The remittance advice remark code of M67 (Missing/Incomplete/Invalid other procedure codes) and remark code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information) will be used as appropriate.)

Further, payment will be denied if submitted for services rendered after the discontinued date (February 26, 2011). If denied, they will use message MSN # 21.11 (This service was not covered by Medicare at the time you received it) and Claims Adjustment Reason Code 27 (Expenses incurred after coverage terminated).

Lastly, contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention with dates of service on and after February 27, 2006.

You can find more information about approval of the \$50 additional payment for NTIOL Category 3 by reviewing CR 4361, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R914CP.pdf>. The revised Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers), Sections 10.2 (10.2 - Ambulatory Surgical Center Services on ASC List) and 40.3 (Payment for Intraocular Lens (IOL)) are attached to CR 4361.

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

# Cardiac Rehabilitation Programs

## Provider Action Needed

Effective on and after March 22, 2006, Medicare has expanded coverage for cardiac rehabilitation programs to include three new indications, and has extended the time frame for performing the services to include up to 36 sessions.

## What You Need to Know

CR 4401 updates the *National Coverage Determination (NCD) Manual*, Publication 100-03, Section 20.10, Cardiac Rehabilitation Programs (March 22, 2006), to include three newly covered indications:

- 1) heart valve repair/replacement;
- 2) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; and
- 3) heart or heart-lung transplant.

It also extends the program's possible duration to a total of 36 sessions (generally, two to three sessions per week for 12 to 18 weeks) and lists the services required to provide a comprehensive program. CR4401 also updates the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140 to include billing requirements and language regarding physician supervision.

## What You Need to Do

Make sure that your billing staffs are aware of these coverage changes in the Cardiac Rehabilitation Program.

## Background

Phase II cardiac rehabilitation, as described by the U.S. Public Health Service, is a comprehensive, long-term program including medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated 1-3 weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

CR 4401 updates *National Coverage Determinations (NCD) Manual* (100-03), Section 20.10 (effective for cardiac rehabilitation services provided on or after March 22, 2006) to:

- Expand the clinical indications for coverage;
- Extend the program's possible duration;
- Simplify the language regarding physician supervision;
- List the services required to provide a comprehensive program; and
- Update the relevant billing and claims related instructions found in the Medicare Claims Processing Manual (Publication 100-04).

CMS has historically covered cardiac rehabilitation services for patients who have: (1) a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) coronary artery bypass surgery; and /or (3) stable angina pectoris. The updated NCD now provides coverage for these three indications and adds three additional ones.

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### **Expanded Coverage**

Effective for services performed on or after March 22, 2006, Medicare covers cardiac rehabilitation exercise programs for patients who meet the following criteria:

- Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
- Have had coronary bypass surgery; or
- Have stable angina pectoris; or
- Have had heart valve repair/replacement; or
- Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- Have had a heart or heart lung transplant.

Further, the updated policy also now allows up to 18 weeks for a beneficiary to receive their maximum of 36 cardiac rehabilitation services (Patients generally receive two to three sessions per week for 12 to 18 weeks).

Please note that additional services may be covered at the discretion of the local Medicare contractor, but may not exceed 72 sessions within a 36-week period.

### **Clarification of Physician and Facility Requirements**

The updated policy also clarifies language regarding physician supervision and facility requirements and the physician's physical location during the rehabilitation services. Specifically the NCD requires that:

- The program must be staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease; and
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator.

The *Medicare Claims Processing Manual* instructs that:

- Cardiac rehabilitation programs shall be performed incident to physician's services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, chapter 6, section 2.4.1, and Pub. 100-02, chapter 15, section 60.1.

### **Coding Requirements**

This CR also changes the Medicare Claims Processing Manual, Publication 100-04, Chapter 32, Section 140, to update the relevant billing and claims related instructions, and points out the following applicable CPT codes:

- 93797 - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session); and
- 93798 - Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).

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You should note that your carriers and FIs will apply current payment methodologies, rates, and payments policies for cardiac rehabilitation services when these services are performed according to the new policy stated in this CR. However, they will not search and adjust claims that have already been processed unless brought to their attention.

### **Additional Information**

The revision of Section 20.10 of the Medicare National Coverage Determinations Manual (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. Remember that:

- NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR 405.1064, effective May 1, 2005);
- A NCD that expands coverage is also binding on a Medicare advantage organization; and
- In addition, an administrative law judge may not review an NCD. (See 1869(f)(1)(A)(i) of the Social Security Act.

You may view CR 4401, Transmittal 52, the revised Medicare National Coverage Determinations Manual, Chapter 1 - Coverage Determinations, Part 1, Section 20.10 (Cardiac Rehabilitation Programs – effective March 22, 2006), at <http://www.cms.hhs.gov/Transmittals/downloads/R52NCD.pdf>.

You may view CR 4401, Transmittal 909, the revised Medicare Claims Processing Manual, Chapter 32 (Billing Requirements for Special Services), Sections 140 (Cardiac Rehabilitation Programs) and 140.1 (Coding Requirements), at <http://www.cms.hhs.gov/Transmittals/downloads/R909CP.pdf>.

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

# Nesiritide for Treatment of Heart Failure Patients

## Key Points

- Effective for dates of service on or after March 2, 2006, the Centers for Medicare & Medicaid Services (CMS) will deny coverage of Nesiritide for the treatment of chronic heart failure in Medicare patients. For billing guidelines about the non-covered use of Nesiritide, please refer to the *Additional Information* section of this article.
- CMS has determined that there is insufficient evidence to conclude that the use of Nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting.
- This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the FDA labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of Nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.
- For claims submitted to FIs, the requirement to deny Nesiritide for chronic heart failure will only affect 13X and 85X Type of Bill (TOBs).
- 11X and 12X TOBs should be rejected.
- CMS recommends that FIs create medical policy parameters to deny outpatient claims for Nesiritide for chronic heart failure in the absence of acutely decompensated heart failure.
- CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (11X and 12X) when billed with Nesiritide for chronic heart failure.
- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and Nesiritide is administered under a DRG payment, the administration of Nesiritide should not be the sole basis for denial of the entire inpatient claim.
- The provider will be held liable unless occurrence code 32 is present on the claim, or HCPCS modifier GA is present on the line on an outpatient bill when Nesiritide is used to treat chronic heart failure without documented evidence of acute decompensation.
- All other indications for the use of Nesiritide not otherwise indicated as noncovered (other off-label uses or uses consistent with the current Food and Drug Administration (FDA) indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.
- This addition to Chapter 1, Section 200.1, of the *Medicare National Coverage Determinations Manual*, (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).

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- NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

## **Background**

Nesiritide is FDA-approved for the short-term intravenous treatment of patients with acutely decompensated CHF who have dyspnea (shortness of breath) at rest or with minimal activity. Recent published studies of Nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with Nesiritide.

In addition, an independent advisory panel of cardiac experts sponsored by Scios, manufacturer of Natrecor® (Nesiritide), recommended that *“The use of Nesiritide should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure who have dyspnea at rest . . . .”*

## **Additional Information**

Claims submitted with HCPCS code J2325 (Injection, Nesiritide) with International Classification of Diseases (ICD-9) codes of:

- 428.0, 428.1, 428.20, 428.22, 428.30, 428.32, 428.40, 428.42, or 428.9; **and not accompanied by:**
- 428.21, 428.23, 428.31, 428.33, 428.41, or 428.43, **will be denied.**

Denied claims will be returned with the following claims adjustment codes:

- **Reason Code:** These are non-covered services because this is not deemed a “medical necessity” by the payer.
- **Remark Code M76:** Missing/incomplete/invalid diagnosis or condition.

Contractors shall apply the following Medicare Summary Notice messages:

- **15.20:** The following policy [NCD 200.1] was used when we made this decision.
- **15.4:** The information provided does not support the need for this service or item.

Contractors shall not search for, but may adjust, claims brought to their attention with dates of service March 2, 2006, through implementation.

## **Relevant Links**

CR 4312 is the official instruction issued to your FI or carrier, regarding changes mentioned in this article. There are two transmittals related to CR 4312. One is transmittal number R51NCD, which relates to the NCD. It may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R51NCD.pdf>.

The second transmittal, R218OTN, relates to Medicare claims processing instructions, and it can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R218OTN.pdf>.

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

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# Percutaneous Transluminal Angioplasty (PTA) Concurrent With The Placement of an FDA-approved Carotid Stent Clarification of Billing Requirements

## Key Points

- This article is based on CR 5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities “approved facilities” Web site link in Publication 100-03, The National Coverage Determinations Manual. The list is now available at <http://www.cms.hhs.gov/MedicareApprovedFacilities/CASF/list.asp>.
- Claims that are being billed for Category B IDE studies and post approval studies, per CR 1660 (effective July 1, 2001) and CR 3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR 3811 (Effective March 17, 2005). The links to CR 1660 and the Medicare Learning Network (MLN) articles relating to CR 3489 and CR 3811 can be found in the Related Links section below.
- CMS created a new section in the Medicare Claims Processing Manual specific to carotid stents. Please refer to this new section in the manual attachment to CR 5022, (Publication 100-04, The Medicare Claims Processing Manual, Chapter 32, Sections 150.1-150.3) for more information about PTA for implanting the carotid stent. (This includes information on CR 660, CR 3489 and CR 3811.)

## Background

Percutaneous Transluminal Angioplasty (PTA) involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of PTA is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased and embolization is decreased. With the development and use of balloon angioplasty for treatment of atherosclerotic and other vascular stenoses, PTA (with and without the placement of a stent) is a widely used technique for dilating lesions of peripheral, renal, and coronary arteries.

Please refer to the manual attachment to CR 5022, Transmittal 53, (Publication 100-03, *The Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 20.7) for more information about the nationally covered indications for PTA concurrent with carotid stent placement, and for facilities accepted for services related to CAS with embolic protection. This is available on CMS’ Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf>.

## Category B IDE Study Claims and Post-approval Study Claims

Effective for dates of service on or after March 17, 2005, the following claims are not subject to the approved facility list. These are CAS claims:

- Billed under a Category B IDE study (identified by a six-digit IDE number preceded by a “G,” e.g., G123456); or a

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- Billed under an FDA-approved post-approval study (identified by a six digit PMA number preceded by a “P,” e.g., P123456)
- Previously denied due to the unintended application of the “approved” facility edit created per CR 3811 that are brought to your FI’s or carrier’s attention will be adjusted (per CR 1660 for Category B IDE Study Claims, and CR 3489 for Post-approval Study Claims).

### **CAS with Embolic Protection Claims**

- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims will be paid only if they are from facilities listed on the approved list (see <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp>). CAS with embolic protection claims from non-approved facilities will be rejected rather than denied. (CR 3811)
- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims that contain CPT code 37216 (transcatheter placement of intravascular stent(s) without distal embolic protection) will not be paid. CMS has deemed CPT code 37216 a non covered service for Medicare purposes.

### **Related Links**

CR 1660, *Claims Processing Instructions for Clinical Trials on Carotid Stenting With Category B Investigational Device Exemptions (IDEs)* can be found on CMS’ Web site at <http://www.cms.hhs.gov/Transmittals/Downloads/AB0174.pdf>.

MM 3489, *Percutaneous Transluminal Angioplasty (PTA)* can be found on CMS’ Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf>.

MM 3811, *Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA)* is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf>.

CR 5022 is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM 5022. CR 5022 may be found by going to Transmittal 911CP at <http://www.cms.hhs.gov/Transmittals/downloads/R911CP.pdf> for the claims processing instructions and to Transmittal 53NCD for the NCD Manual section, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf> on the CMS Web site.

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

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# New Requirements for Low Vision Rehabilitation Demonstration Billing

**Note:** Please note that MLN Matters article MM 5023 contains updated information regarding remittance advice and remark codes and regarding the use of provider identifiers, especially UPINs and the National Provider Identifier. MM 5023 is based on CR 5023, released on April 28, 2006. To see MM 5023, go to the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5023.pdf>.

## Provider Action Needed

Physicians, providers and suppliers should note that the Centers for Medicare & Medicaid Services (CMS) is:

- Implementing an outpatient vision rehabilitation demonstration project in selected areas across the country to examine the impact of standardized Medicare coverage for vision rehabilitation services; and
- Extending coverage under Part B for the same services to provide vision rehabilitation that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a vision rehabilitation professional under the general supervision of a qualified physician.

This demonstration project will last for five years through March 31, 2011 and is limited to services provided in specific demonstration locales. **These areas are New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.**

## Background

The Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany Public Law HR 2673. This demonstration project will examine the impact of standardized Medicare coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians;
- Occupational therapists;
- Certified low vision therapists;
- Certified Orientation and mobility specialists; and
- Certified Vision Rehabilitation Therapists.

Under this Low Vision Rehabilitation Demonstration, Medicare is extending coverage under Part B for the same rehabilitation services to treat vision impairment that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a certified vision rehabilitation professional under the general supervision of a qualified physician. This demonstration will last for five years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all 5 boroughs), North Carolina, Atlanta, Kansas, and Washington State. Payment for vision rehabilitation services under this demonstration may be made to:

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- Either the qualified physician who is supervising the occupational therapist or certified vision rehabilitation professional; or an occupational therapist in private practice; or
- A qualified facility, such as a rehabilitation agency or clinic that has a contractual relationship with the certified vision rehabilitation professional; and
- Where the services are furnished under the individualized written plan of care. Payment for these services will be made under the physician fee schedule even when such services are billed by a facility. They are not subject to bundling under the Outpatient Prospective Payment System (OPPS).

Under this Low Vision Rehabilitation Demonstration, Medicare will cover low vision rehabilitation services to people with a medical diagnosis of moderate or severe vision impairment that is not correctable by conventional methods or surgery (i.e., cataracts).

Services will be provided under an individualized, written plan of care developed by a qualified physician or qualified Occupational Therapist in Private Practice (OTPP) that is reviewed at least every 30-days by a qualified physician. The plan of care must attest that vision rehabilitation services are medically necessary and the beneficiary receiving vision rehabilitation is capable of receiving rehabilitation and deriving benefit from such services, and should include:

- An initial assessment which documents the level of visual impairment;
- Specific measurable goals to be fulfilled during rehabilitation and the criteria by which the goals will be measured;
- The location of where the rehabilitation services will be conducted;
- Description of specific rehabilitative services to be directed toward each goal provided during the course of rehabilitation; and
- A reasonable estimate of the amount of treatment necessary to reach the goals.

Rehabilitative services will be conducted within a three-month period of time, in intervals appropriate to the patient's rehabilitative needs, and will not exceed 36 units of 15 minutes each, or 9 hours total.

Rehabilitation will be judged completed when the treatment goals have been attained and any subsequent services would be for maintenance of a level of functional ability, or when the patient has demonstrated no progress on two consecutive visits.

All services covered under this demonstration are one-on-one, face-to-face services. Group services will not be covered.

Vision rehabilitation services will be furnished in an appropriate setting, including the home of the individual receiving the services, as specified in the plan of care and can be provided by the following:

- A qualified physician as defined in the Social Security Act (Section 1861r (1) and (4)) and who is an ophthalmologist or a doctor of optometry;
- A qualified occupational therapist in private practice;
- A qualified occupational therapist who is an employee of the physician; or

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- A certified vision rehabilitation professional including low vision therapists, orientation and mobility specialists, and vision rehabilitation therapists who have received certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).
- Occupational therapists employed by the physician and certified vision rehabilitation professionals may furnish services while under the general supervision of a qualified physician. General supervision means that the physician does not need to be “on premises” nor in the immediate vicinity of the rehabilitation services as would be the case with “incident to” requirements stated in Section 2050 of the Medicare Carriers Manual.
- Payment for vision rehabilitation services will be made to the qualified physician under the Medicare Physician Fee Schedule (MPFS) or to a facility, including the following:
  - Hospitals;
  - Comprehensive Outpatient Rehabilitation Facilities (CORF);
  - Other rehabilitation agencies or clinics; or
  - Facilities that bill Medicare for providing occupational therapy, through which services are furnished under an individualized, written plan of care.

Occupational therapists in private practice may also submit claims under their own provider number for providing low vision rehabilitation services. However, for occupational therapists in private practice who are participating in the low vision rehabilitation demonstration, claims submitted must contain the same information as on a physician’s claim form and must use the demonstration “G” HCPCS code for occupational therapists (HCPCS code G9041) for the claim to be considered. Occupational therapists in private practice may not supervise therapy assistants or certified low vision rehabilitation professions, nor may they submit claims for the services of these individuals under the demonstration.

Certified vision rehabilitation professionals provide services pursuant to a plan of care and under the general supervision of the qualified physician who develops the plan of care. However, if the certified vision rehabilitation professional has a contractual arrangement with the facility where services are furnished, the facility may submit the bill for services.

Payment to practitioners and facilities will be made using the Medicare Physician Fee Schedule (MPFS) with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will not be paid under the OPFS system. Payment for services under this demonstration is limited to low vision rehabilitation. E/M services are not billable under the demonstration.

Vision impairment refers to significant vision loss from disease, injury or degenerative condition that cannot be corrected by conventional means, such as medication or surgery. The impairment must be manifest by one or more of the conditions listed in the following table:

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Levels of Vision Impairment	Description
Moderate Visual impairment	Best corrected visual acuity is less than 20/60 in the better eye (including a range of 20/70 to 20/160)
Severe visual impairment (legal blindness)	Best corrected visual acuity is less than 20/160 including 20/200 to 20/400; or visual field diameter is 20 degrees or less (largest field diameter for Goldman isopter III4e, 1/100 white test object or equivalent) in the better eye.
Profound visual impairment (moderate blindness)	Best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
Near-total visual impairment (severe blindness)	Best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less.
Total visual impairment (total blindness)	No light perception

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes included in the following table will be used to support medical necessity for coverage under the demonstration.

ICD-9-CM Code	Description
368.41	Scotoma involving central area
368.45	Generalized contraction or constriction
368.46	Homonymous Bilateral Field Defect
368.47	Heteronymous Bilateral Field Defect
369.01	Better Eye: Total Vision Impairment Lesser Eye: Total Vision Impairment
369.03	Better Eye: Near-Total Vision Impairment Lesser Eye: Total Vision Impairment
369.04	Better Eye: Near-Total Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.06	Better Eye: Profound Vision Impairment Lesser Eye: Total Vision Impairment
369.07	Better Eye: Profound Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.08	Better Eye: Profound Vision Impairment Lesser Eye: Profound Vision Impairment
369.12	Better Eye: Severe Vision Impairment Lesser Eye: Total Vision Impairment

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ICD-9-CM Code	Description
369.13	Better Eye: Severe Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.14	Better Eye: Severe Vision Impairment Lesser Eye: Profound Vision Impairment
369.16	Better Eye: Moderate Vision Impairment Lesser Eye: Total Vision Impairment
369.17	Better Eye: Moderate Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.18	Better Eye: Moderate Vision Impairment Lesser Eye: Profound Vision Impairment
369.22	Better Eye: Severe Vision Impairment Lesser Eye: Severe Vision Impairment
369.24	Better Eye: Moderate Vision Impairment Lesser Eye: Severe Vision Impairment
369.25	Better Eye: Moderate Vision Impairment Lesser Eye: Moderate Vision Impairment

Most rehabilitation is short-term and intensive, and sessions are generally conducted over a consecutive 90-day period of time with intervals appropriate to the patient's rehabilitative needs.

Patients usually receive therapy 1-2 times per week, and not less frequently than once every two weeks. The sessions are generally 30-60 minutes in duration.

Periodic follow-up and evaluation should be documented by the physician at least every 30 days during the course of the rehabilitation.

For the purposes of this demonstration, vision rehabilitation services will not be subject to physical or occupational therapy caps.

CMS established four different series of temporary demonstration, or "G" HCPCS codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary. That instruction, CR 3816, may be viewed by going to CMS' Web site at <http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage>.

From that Web page, look for CR 3816 and CR 4294, and click on the files for those CRs. **Example "G" HCPCS codes** include:

- HCPCS code G9041 for services provided by a qualified occupational therapist;
- HCPCS code G9042 for services provided by a certified orientation and mobility specialist; and
- HCPCS code G9043 for services provided by a certified low vision rehabilitation therapist; and
- HCPCS code G9044 for services provided by a certified vision rehabilitation therapists.

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Payable Places Of Service (POS) for Part B claims include:

- Office (11);
- Home (12);
- Assisted living facility (13);
- Group home (14);
- Custodial care facility (33); and
- Independent clinic (49).

In addition, facilities that are qualified to submit claims include the following:

- Outpatient hospital clinics (TOB 13x);
- Outpatient CAH clinics (TOB 85x);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs) (TOB 75x); and
- Freestanding rehabilitation clinics (TOB 74x).

Fiscal intermediaries (FIs) will use the claim related condition code 79 to indicate when services are provided outside the facility. When no condition code appears it will indicate that rehabilitation services were provided in the facility. Providers will be required to indicate either no code or code 79 on claims.

Facility claims will also use the revenue code 0949 (other rehabilitation services) in addition to the demonstration G HCPCS code, which indicates the type of professional who provided the rehabilitation service.

This will apply to all institutional settings and CAH outpatient departments. CAHs that elect to use method II billing will use revenue code 0969 or revenue code 0962, whichever is most appropriate.

Carriers will accept and process claims from qualified physicians when those claims include:

- An appropriate ICD-9-CM code that supports medical necessity;
- An appropriate rehabilitation “G” HCPCS code for the demonstration; and
- Evidence of a written plan of care that specifies the type and duration of the rehabilitative services being furnished.

The plan of care and date can be indicated in block 19 (Reserved for Local Use) of the CMS-1500 claim form. Facilities will use occurrence code 17 for date the plan of care was established or reviewed.

Qualified physicians, occupational therapists and low vision professionals practicing in designated demonstration areas may provide low vision rehabilitation services to eligible residents of the demonstration areas.

Approved demonstration locales are limited to the following; New Hampshire, New York City (all 5 boroughs), North Carolina, Atlanta, Kansas, and Washington State.

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Providers should note that the residence of the beneficiary receiving services and the physician or facility providing the services must be in the same approved demonstration locale (state or metropolitan area) as determined by matching primary residence and primary practice zip codes.

### **Implementation**

The implementation date for this instruction is April 3, 2006.

### **Additional Information**

As previously mentioned above, CMS will establish four different series of temporary demonstration, or “G” HCPCS codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

You can view the official instruction issued to your carrier/intermediary for complete details regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage>. Search for 3816 and 4294 in and click on the file for those CRs.

For additional information relating to this issue, please contact our office at 1-877-567-9232.

# Additional Clarification of CR 3816 Business Requirements – Low Vision Rehabilitation Demonstration

## Providers Action Needed

This article is based on Change Request (CR) 5023 and this article actually revises the article for CR 3816 by providing specific information clarifying billing instructions as directed in the Administrative Simplification Compliance Act (ASCA). Be aware that:

- National Provider Identification numbers (NPI) replace physician UPIN numbers by May 23, 2007.
- CR 3816 for the Low Vision Rehabilitation Demonstration states that **providers** are to document the plan of care by indicating the date the plan was developed or reviewed in Block 19 (Reserved for Local Use) of the CMS-1500 claim form or its electronic equivalent.
  - **This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.**
- **Facilities** must document the date the plan of care was established or reviewed using occurrence code 17 on CMS-1450 or its electronic equivalent.
  - **This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.**

## Background

According to CR 3816, the date the plan of care was established was to be placed in Block 19 of the CMS-1500 claim form. However, there is no place for this information in the electronic claims form. Therefore, this requirement has been removed whether submitting a paper claim or an electronic claim by providers or facilities.

In addition, although the business requirements in CR 3816 mention use of remittance advice messages, and the background makes reference to using the most appropriate Medicare summary notice (MSN) messages unless specified otherwise in the business requirements, there is no corresponding reference to the remittance advice message in the background.

Please note that your carrier/FI will use the most appropriate remittance advice and remark codes when denying a claim unless otherwise specified in CR 3816.

## Implementation

The implementation date for the instruction is July 28, 2006.

## Additional Information

For details of enforcement of the ASCA, please see related MLN Matters article MM 3440, “Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims,” at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3440.pdf>.

To view the MLN Matters article related to CR 3816, go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3816.pdf>. The official instructions issued to your intermediary or carrier regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R46DEMO.pdf>.

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# Therapy Services

## Provider Action Needed

This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term “speech therapy” to “speech-language pathology.”

## What You Need to Know

To conform to changes in CR 3648, CR 4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist. Requirements for therapy services incident to a physician have not been changed.

## What You Need to Do

See the *Background* section of this article for further details regarding these changes.

## Background

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: the term “speech therapy” is being changed to “speech-language pathology.”

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR 3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR 3648 can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>.

Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer’s adjudication process:

- Date last seen; and
- The Unique Provider Identification Number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided “incident to” the services of a physicians or nonphysician practitioners (NPP), in which case it is required. CR 4014 updates instructions in CR 3648 (related to claims for services “incident to” a physician’s/NPP’s service) by acknowledging that:

- The “incident to” service can be identified only on prepay or postpay review;
- Manual review of all therapy claims is not required; and
- “Incident” to policies have not changed and still apply to therapy services.

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CR 4014 also clarifies selected business requirements in CR 3648 to indicate that some contractor actions:

- Will occur on prepay or postpay review;

For example, compare the following:

**Business Rule (BR) 3648.8** – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals; with

**BR 4014.8 – On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005**, contractors shall pay for **physical therapy and occupational** therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.

- Should not be applied to services “incident to.” (e.g., BR 3648.3 – Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or postpay review).

CR 3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed “incident to” a physician.

Therefore, when a therapy service is billed “incident to,” the following requirements remain in effect because they are required by “incident to” policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

### **Implementation**

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

### **Additional Information**

CR 3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services) can be reviewed at [http://www.cms.hhs.gov/manuals/pm\\_trans/R36BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf).

The MLN Matters article, MM 3648 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf>.

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For complete details, please see the official instructions (CR 4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR 4014, the NCD, transmittal 55 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf>. Transmittal 941 is the *Medicare Claims Processing Manual* update, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R941CP.pdf>.

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

# Screening Mammography Claims ~ Correct Reporting of Diagnosis Codes

## Providers Action Needed

This article and Change Request (CR) 5050 provides specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

In addition, CR 5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It **removes 12X type of bill (TOB)** from the list of applicable TOBs for diagnostic mammography;
- It **adds HCPCS code G0202** to the list of valid codes for the billing of screening mammography; and
- It **adds HCPCS codes G0204 and G0206** to the list of valid codes for the billing of diagnostic mammographies.

## Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

## Implementation

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

## Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf>. The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR 5050.

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

# Whole-Body CT Scans

In recent years a new CT scan, often referred to as a comprehensive diagnostic screening examination, virtual physical, full-body scan, whole-body CT scan or whole-body CT screening, has gained popularity due to promotion by various media outlets, equipment manufacturers and imaging facilities. The study is described as proactive or preventive in nature and is marketed to people who are healthy and have no signs or symptoms of any illness. The FDA position on this study indicates that they have found no evidence that whole-body CT screening increases the likelihood of cure or improves the treatment or management of the disease process due to earlier detection. Furthermore, while devices for CT imaging continue to be cleared for marketing for general imaging purposes by the FDA, no data have been presented to the FDA to demonstrate that these devices are effective for **screening**, i.e., testing individuals without symptoms. Statements that say or imply that FDA has approved CT scanning for whole-body screening uses are not correct.

It has been discovered that some Medicare providers are attempting to obtain reimbursement for whole-body CT scans by submitting claims for CT scans of the abdomen, pelvis and thorax on the same day to the same beneficiary. While Medicare has expanded coverage to include a limited number of screening and/or preventive procedures, the whole-body CT scan has not received such approval for coverage. The only preventive physical covered by Medicare at this time is the “Welcome to Medicare” visit. This is a one-time service available to new beneficiaries of the Medicare program in the first six months of their Medicare Part B coverage.

Providers submitting claims for CT scans of the abdomen, pelvis and thorax for the same beneficiary on the same day may be subject to payment denial and further review in the form of medical record request to determine the medical necessity of such claims.

# Medical Review - Frequently Asked Questions (FAQs) ~ May 2006

“Frequently Asked Questions... Answered for You!”

## **1. Does Palmetto consider Coumadin and Rocephin drug therapy to be high risk when determining the level of risk for an E/M service?**

**Answer:** Coumadin and Rocephin are not examples of drugs that require intensive monitoring for *toxicity*. Coumadin monitoring is not intensive and the *drug is not toxic* – the monitoring is needed to keep the dose in the effective range but usually is only done monthly after initial implementation. Examples of drugs categorized as high risk, are most chemotherapy drugs and certain cardiac drugs with narrow therapeutic ranges such as Amiodarone. If you look in a drug book, you will see that Amiodarone is listed as “toxic”, but drugs like Coumadin and Rocephin are not.

Administration of chemotherapy is always considered High Risk under management options. The longer you give chemo medications, the riskier it is. The physician’s decision making is based upon his/her own checklist as they evaluate the patient. When the physician is consistently billing the higher level office visit, we would expect to see documentation that would establish this, such as recognizing major toxicity or a reference back to another note.

Determination of risk is complex and not readily quantifiable. It is up to the physician to determine whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high.

## **2. Why are the claims I submit for chronic renal dialysis transport denied even though I have a fax approval from Palmetto?**

**Answer:** The fax decision is a coverage decision only. There can still be questions or denials due to eligibility or coverage issues. The fax decision is based solely on whether coverage provisions have been met. It is possible that the claim may be denied for reasons of eligibility, entitlement, or other reasons, after the determination of coverage. Medical records and other pertinent documentation, submitted by the provider of service, are used to make this initial coverage decision.

## **3. Why don’t I get a fax for each claim I submit for dialysis transport?**

**Answer:** Medical Review clinicians review all documentation received for a Parent Claim and render a coverage decision. If the decision is to noncover, the Parent Claim is denied and the provider receives a fax notification of their noncoverage decision. In addition, the provider will receive a notice of denial on the remittance advice. Any pending subsequent claims for dates of service that fall within the 90-day period of noncoverage will subsequently be denied.

\_\_\_\_ Continued on next page

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If the clinician approves coverage, the claim is processed (approved, for “medical review” purposes). All pending subsequent claims on file for the review period will be processed for payment.

You will receive a fax only for those claims where the Medical Review Clinician makes a coverage decision. You will not receive a fax for those claims not reviewed individually by the Medical Review clinician.

**4. Why do I receive faxes with approvals and denials for the same patient for dialysis transports? The claims are for different dates of service.**

**Answer:** Any claims that fall outside a defined coverage period require a new “Parent Claim”, the first claim to define a coverage period. If the claims for this patient are before or after the approved coverage period and the documentation is insufficient or does not support the medical necessity for the transport, then a denial decision is made.

You can call the Provider Contact Center at 1-877-567-9232 for information concerning covered dates of service.

You may appeal the denial once you receive your remittance advice. The redetermination process for Chronic Renal Disease Repetitive Ambulance Transport claims will be handled the same way as they are now for any denied service with appeal rights.

Requests for redeterminations must be submitted in writing, within 120 days of the initial determination (i.e., date on your remittance advice) and include the following:

- Patient’s name;
- Medicare health insurance claim (HIC) number;
- The specific service(s) and/or item(s) for which the redetermination is being requested;
- The specific date(s) of service;
- A legible signature of the party OR the representative of the party;
- A copy of the originally requested records;
- A brief explanation of why you want the claim reviewed; and
- Any additional information that may or may not have been available when the records were initially requested and examined MUST be enclosed.

You may also submit:

- A copy of the original claim. Electronic billers should provide a paper claim copy or a complete description of the service in question.
- A copy of the Remittance Advice Notice statement

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The request for redetermination, with all of the information, must be sent to the following address:

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

If your appeal results in a change to the coverage period (i.e., claims for dates of service during this period will be allowed as a result of the appeal), any subsequent claims that are submitted after the appeal decision will be allowed for the period identified in the redetermination reversal.

**5. I have submitted a redetermination request for a dialysis ambulance transport. Who do I call to check on the status of the redetermination? A Medical Review Department clinician made the denial. Do I call the voice mail contact for the Medical Review nurse or the Provider Contact Center?**

**Answer:** You can call the Provider Contact Center at 1-877-567-9232 for all information relating to the redetermination process and the status of your claim. The Medical Review Department answers inquiries regarding the faxed coverage determination for dialysis ambulance transports only.

## 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 Contact Center at 1-877-567-9232.

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

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

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

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### Local Coverage Determination Update

LCD	Change	Effective Date
Cancer Chemotherapy & Chemotherapeutic Agents 2002-29LR23	Addition of ICD-9 code 204.10 as supporting medical necessity for HCPCS code J9268 (Pentostatin).	04/14/2006

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**MEDICARE**

**Part A Intermediary**

**Part B Carrier**

**DME Regional Carrier**

**RECONSIDERATION REQUEST FORM - QIC West**

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

**Q2 Administrators, LLC  
Part B West Operations  
PO Box 100213  
Columbia, South Carolina 29202-0213**

1. Name of Beneficiary: \_\_\_\_\_

2. Medicare Number: \_\_\_\_\_

3. Provider Name and Number: \_\_\_\_\_

4. Person Appealing: Beneficiary      Provider of Service      Representative

5. Address of Person Appealing: \_\_\_\_\_  
\_\_\_\_\_

6. Item or service you wish to appeal: \_\_\_\_\_

7. Date(s) of service: \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_

8. Does this appeal involve an overpayment:    Yes    No

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

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

- |                                  |                               |                |
|----------------------------------|-------------------------------|----------------|
| Medical Records                  | A copy of the Claim           | Treatment Plan |
| Certificate of Medical Necessity | Office Notes / Progress Notes |                |

11. Printed Name of Person Appealing: \_\_\_\_\_

12. Signature of Person Appealing: \_\_\_\_\_ Date: \_\_\_\_\_

Appeal Number: \_\_\_\_\_ Contractor Number: 00883  
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

Palmetto GBA –Ohio/WV Medicare Part B Carrier (Carrier 00883)  
Post Office Box 182934 \* Columbus, Ohio \* 43218-2394  
Beneficiary Service Center: (800) MEDICARE \* Provider Service Center: (877) 567-9232  
A CMS Contracted Intermediary and Carrier

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**MEDICARE**

**Part A Intermediary**

**Part B Carrier**

**DME Regional Carrier**

**RECONSIDERATION REQUEST FORM - QIC East**

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

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

1. Name of Beneficiary: \_\_\_\_\_

2. Medicare Number: \_\_\_\_\_

3. Provider Name and Number: \_\_\_\_\_

4. Person Appealing: Beneficiary      Provider of Service      Representative

5. Address of Person Appealing: \_\_\_\_\_  
\_\_\_\_\_

6. Item or service you wish to appeal: \_\_\_\_\_

7. Date(s) of service: \_\_\_ / \_\_\_ / \_\_\_ TO \_\_\_ / \_\_\_ / \_\_\_

8. Does this appeal involve an overpayment:    Yes    No

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

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

- |                                  |                               |                |
|----------------------------------|-------------------------------|----------------|
| Medical Records                  | A copy of the Claim           | Treatment Plan |
| Certificate of Medical Necessity | Office Notes / Progress Notes |                |

11. Printed Name of Person Appealing: \_\_\_\_\_

12. Signature of Person Appealing: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

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

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

Provider Name: \_\_\_\_\_

Practice or Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Phone Number (including area code): \_\_\_\_\_

Identify All Applicable Medicare Provider Identification Numbers (PINs):  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date you wish this Opt Out to become effective\*: \_\_\_\_\_

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

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

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

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

For more information please see CMS' Web site at <http://www.cms.hhs.gov/MLNMattersArticles/> (refer to article MM3827).

**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 and West Virginia

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



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

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

### General Information

Patient's name \_\_\_\_\_  
 Health Insurance Claim (HIC) number \_\_\_\_\_  
 Date of initial determination \_\_\_\_\_  
 CPT code(s) \_\_\_\_\_  
 ICD-9 code(s) \_\_\_\_\_  
 Performing provider number \_\_\_\_\_  
 Billing provider number \_\_\_\_\_  
 Phone number \_\_\_\_\_  
 Date of service \_\_\_\_\_

**This is an appeal for:**

- |   |  |  |
|---|--|--|
| <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"/> CRD/ESRD service     | <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"/> Office Notes     |
| <input type="checkbox"/> Advance Notice Statement          | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Claim Copy                        | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Medical Necessity Statement       | <input type="checkbox"/> Treatment Plan   |

Reason for request: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Requestor (signature required): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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## CMS Offers FREE Medicare Training for Providers

### CMS Web Training

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

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

## Palmetto GBA Medicare Customer Information and Outreach

### Important Telephone Numbers

#### Provider Call Center

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

TTY 1-877-391-9739

#### Provider Enrollment Support Line

1-866-308-5439

#### Electronic Data Interchange (EDI) Technical Support

1-866-308-5438

#### Medicare Secondary Payer

1-866-308-5442

#### Telephone Reopenings

1-866-308-5441

#### Medicare Fraud Hotline

1-888-619-5316

#### Medicare Patient Call Center

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

TTY 1-877-486-2048

### FREE Training Available

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

Palmetto GBA  
4249 Easton Way  
Columbus, OH 43219

<http://www.PalmettoGBA.com>

### Important Sources For You

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

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

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