Medicare advisory

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2007, Issue 6 *www.cms.hhs.gov* *www.PalmettoGBA.com* *June 2007*

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You Are Responsible. . .

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

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

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Paper Claims: Reporting Up To 8 ICD-9-CM Codes

Effective for claims processed July 1, 2007, and after, up to eight ICD-9-CM codes may be submitted on Medicare claims. Historically, Medicare used only the first four ICD-9-CM codes when processing claims and has used a manual process to consider the remaining ICD-9-CM codes in the payment determinations. This change will allow Palmetto GBA to process claims using all ICD-9-CM codes reported on the claim (up to eight). Although up to eight ICD-9-CM codes may be reported, you need only submit the number of ICD-9-CM codes necessary to support the service that was rendered. In order for Palmetto GBA to correctly process claims submitted with more than four ICD-9-CM codes, please submit paper claims as follows:

Providers and suppliers must place **two ICD-9-CM codes in each of the fields** (1-4) in item 21 of the CMS-1500 claim form when **more than four** ICD-9-CM codes are submitted. These two ICD-9-CM codes must be **separated by a space, comma, or dash in order for us to validate the submitted ICD-9-CM codes.**

If the ICD-9-CM codes are not submitted as indicated, your paper claim may be delayed or processed without having all submitted ICD-9-CM codes considered.

For additional information, refer to CMS *MLN Matters* article MM 5441: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5441.pdf.

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National Provider Identifier (NPI): Medicare Fee-For-Service (FFS) Contingency Plan

Note: This article was revised on April 24, 2007, to reflect changes made to CR 5595, which CMS re-issued on April 24. The article was changed to reflect in bold print on page 2 that "As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners". The article also has a revised transmittal number, release date, and Web address for accessing CR 5595. All other information remains the same.

Provider Action Needed

Impact to You

As early as July 1, 2007, Medicare fee for service (FFS) contractors may begin rejecting claims that do not contain an NPI for the primary providers.

What You Need to Know

CR 5595, from which this article is taken, announces that (effective May 23, 2007) Medicare fee for service (FFS) is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007.

What You Need to Do

If you have not yet done so, you should obtain your NPI now. You can apply on line at https://nppes.cms.hhs.gov/ on the CMS Web site**.** You should also make sure that your billing staffs begin to include your NPI on your claims as soon as possible.

Background

The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that each physician, supplier, and other health care provider conducting HIPAA standard electronic transactions, be issued a unique national provider identifier (NPI). CMS began to issue NPIs on May 23, 2005; and to date, has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only,
- Medicare legacy only, or
- An NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for NPI implementation. **As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency**

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plans to facilitate the compliance of their trading partners. (You can find this guidance on the CMS Web site at: http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf.)

In CR 5595, from which this article is taken, Medicare fee for service (FFS) announces that it is establishing a contingency plan that follows this DHHS guidance. For some period after May 23, 2007, Medicare FFS will:

- Allow continued use of legacy numbers on transactions;
- Accept transactions with only NPIs; and
- Accept transactions with both legacy numbers and NPIs.

After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is determined sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers following appropriate notification. (*See Important Information* below.)

In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If this analysis demonstrates a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims without NPIs on July 1, 2007. If, however, there are not sufficient claims containing NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007.

CMS also recognizes that the National Council of Prescription Drug Programs (NCPDP) format only allows for reporting of one identifier. Thus, NCPDP claims can contain either the NPI or the legacy number, but not both, until May 23, 2008.

In addition, in regards to the 835 remittance advice transactions and 837 Coordination of Benefits (COB) transactions, Medicare FFS will do the following until May 23, 2008:

- If a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice; otherwise, the legacy number will be sent on the associated 835.

- If a claim is submitted with an NPI, the associated 837 COB transaction will be sent with both the NPI and the legacy number; otherwise, only the legacy number will be sent.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via the Extranet and Internet must contain the NPI.

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Important Information

CR 5595 also provides specific important information that you should be aware of:

- Once a decision is made to require NPIs on claims, Medicare FFS will notify (in advance) providers and Medicare contractors about the date that claims without NPIs for primary providers will begin to be rejected. **That date will supersede all dates announced in previous CRs and *MLN Matters* articles.**

- In editing NPIs, Medicare considers billing, pay-to and rendering providers to be primary providers who must be identified by NPIs, or the claims will be rejected once the decision is made to reject.

- All other providers (including referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and "other" providers) are considered to be secondary providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If a secondary provider's NPI is present, it will only be edited to assure it is a valid NPI.

Additional Information

You can read CR 5595 at http://www.cms.hhs.gov/Transmittals/downloads/R1227CP.pdf on the CMS Web site and learn more about the NPI at http://cms.hhs.gov/NationalProvIdentStand/.

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

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Skilled Nursing Facility: Invalid Informational Unsolicited Responses & Medicare's Common Working File (CWF) System

Provider Action Needed

Impact to You

Medicare systems may have inadvertently rejected outpatient, Part B, and DME claims that overlapped periods of a SNF stay by a beneficiary, whose Medicare SNF benefits were exhausted and for whom a non-pay SNF claim was submitted to Medicare.

What You Need to Know

This problem may have affected some of your claims processed by Medicare from October 2, 2006, until January 29, 2007, when Medicare systems were fixed.

What You Need to Do

You need not take any action as your Medicare contractor will take steps to adjust any claims affected and to reverse or stop any payment recovery actions. See the Background section for more details.

Background

Providers need to be aware that the Centers for Medicare & Medicaid Services (CMS) has identified an issue with processing outpatient, Part B, and DME claims for beneficiaries who are in a SNF, but whose Medicare coverage for the SNF stay has ended. In October of 2006 Change Request (CR) 4292 (Benefits Exhaust and No-Payment for Medicare FIs and SNFs) was implemented. CR 4292 (see *Additional Information* section for the CMS Web site address of CR 4292) mandated that providers submit ALL SNF non-pay claims after benefits were exhausted to allow CMS to track the beneficiary's benefit period.

Medicare system changes relating to CR 4292 caused outpatient, Part B, and DME paid claims that overlap non-pay SNF claims to be rejected. **This is an error and your Medicare contractor will adjust claims or payment recovery actions resulting from this problem.** The CWF coding change to fix this problem was effective and in production on January 29, 2007, and CWF will provide a list of claims to the applicable contractors to allow for corrections and payment to be made to providers.

Key Points

CMS has directed Medicare contractors to correct any claims that were adjusted as a result of the problem with implementation of CR 4292.

Any providers whose claims were impacted will be paid any payment recovered to include any interest charged.

Where the payment recovery has not occurred, the Medicare contractor will stop such action.

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Additional Information

For complete details regarding this CR please see the official instruction (CR 5587) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R274OTN.pdf.

The *MLN Matters* article for CR 4292, *Benefits Exhaust and No-Payment for Medicare FIs and SNFs* can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4292.pdf.

If you have questions, please contact 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.treasurydirect.gov/govt/rates/tcir/tcir_opdprmt2.htm.

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Remark Code MA130: “Billing Errors”

Have you seen MA130 on your remittance notice? Do you know what to do when you see it?

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.

Do you know what to do next?

- Complete or correct the necessary information on the claim and resubmit it as a new claim.
- Important: look in the remark code area specific to the line-level claim information for more specific remark codes. These are circled in red on the example below.
- The November 2006 Medicare Advisory contains a 3 page article about rejected claims including a table that show examples of unprocessable claim situations. Medicare Advisories are available on our Web site:
  - Ohio: http://www.PalmettoGBA.com/boh/advisory
  - West Virginia: http://www.PalmettoGBA.com/bwv/advisory
- A list of the most common billing errors is available at your fingertips on the Palmetto GBA Web site. The Claim Resource Lookup Web page walks you through the steps for correcting and preventing the most common errors. Access this handy guide from the “Cool Tools” section of the Ohio and West Virginia home pages.

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Not sure what needs to be corrected?

- Customer service representatives are available from 8:30 a.m. – 4:30 p.m., Monday through Friday to assist you with more complex questions or concerns. Please call us if we can help: 1-877-567-9232.

Be sure to share this information with your billing office, especially if they are the ones that receive the RA (Remittance Advice).

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

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Model Medicare Redetermination Notice (MRN)

Modifications have been made to the Model Medicare Redetermination Notice (MRN) (for partly or fully unfavorable redeterminations) and the Administrative Law Judge (ALJ) filing locations where the place of service was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands.

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), durable medical equipment regional carriers (DMERCs), and/or regional home health intermediaries (RHHIs)).

Provider Action Needed

Impact to You

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the ALJ filing locations.

What You Need to Know

Providers and suppliers do not need to resubmit documentation when requesting a Qualified Independent Contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US Virgin Islands,** the filing locations for ALJ requests **are modified** to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

What You Need to Do

Make certain that your billing staff or other staff that handle reconsideration requests for you are aware of these changes.

Background

CR 5554 is the official document that announces these changes in Medicare processes. Attached to this CR are three documents that assist with the appeals process:

- A sample form letter titled: Medicare Appeal Decision,
- A paper outlining Important Information About Your Appeal Rights, and
- A modified **Reconsideration Request Form** containing revised introductory instructions, as follows: "At a minimum, you must complete/include information for items 1, 2a, 6, and 7 but to help us serve you better, please include a copy of the redetermination notice you received with your reconsideration request."

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The revised filing locations for sending documentation for requesting ALJ hearings are as follows:

- **Cleveland, Ohio** is the filing location for services rendered in **Delaware and Kentucky,**
- **Arlington, Virginia** for services in **Virginia, and**
- **Miami, Florida** for services in **Puerto Rico and the US Virgin Islands.**

The following table lists the addresses of all filing locations along with the place of service.

HHS OMHA Field Office & Mailing Address	**Jurisdiction (Based on the place of service)**			
Cleveland, OH BP Tower & Garage 200 Public Square, Suite 1300 Cleveland, OH 44114-2316	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	New York New Jersey Puerto Rico Virgin Islands	Pennsylvania ***Delaware*** West Virginia ***Kentucky***	Illinois Indiana Ohio Michigan Minnesota Wisconsin
Miami, FL 100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Alabama Florida Georgia Mississippi North Carolina South Carolina Tennessee	Arkansas Louisiana New Mexico Oklahoma Texas ***Puerto Rico*** ***US Virgin Islands***		
Irvine, CA 27 Technology Drive, Suite 100 Irvine, CA 92618-2364	Iowa Kansas Missouri Nebraska	Colorado Montana North Dakota South Dakota Utah Wyoming	Arizona California Hawaii Nevada Guam Trust Territory of the Pacific Islands American Samoa	Alaska Idaho Oregon Washington
Arlington, VA 1700 N. Moore St., Suite 1600 Arlington, VA 22209	***Virginia*** Maryland District of Columbia			

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Additional Information

For complete details regarding this Change Request (CR), please see the official instruction (CR 5554) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1229CP.pdf.
If you have questions, please contact our office at 1-877-567-9232.

CMS Quarterly Provider Update

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

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

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

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

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Disclosure Desk Reference for Provider Contact Centers

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

Impact to You

When you call or write a Medicare fee-for-service provider contact center (PCC) to request patient protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

What You Need to Know

CR 5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request patient protected health information, and to clarify the information they may disclose after authentication.

What You Need to Do

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request patient protected health information before disclosing it to the requestor.

CR 5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request patient protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

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Below is the authentication guidance that the PCCs will be using:

Telephone Inquries

Provider Authentication

CSR Telephone Inquiries - Through May 22, 2007, Customer Service Representatives (CSR) will authenticate providers using provider number and provider name.

Interactive Voice Response (IVR) Telephone Inquiries - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

Written Inquiries

Provider Authentication

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no patient-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for patient-specific information.

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the top edge of the form, then the form is not printed to specifications. There should be approximately ¼" between the tip of the arrow and the top edge of the paper on properly formatted forms.

- Providers submitting the Form CMS-1500 (12-90) are only required to submit their legacy provider number on that form, since the CMS-1500 (12-90) cannot accommodate the NPI. ***It is important to note that this issue involves the paper claim form only, not the electronic claim format, which can accommodate the NPI. In addition, this situation does not affect the current NPI implementation date of May 23, 2007.***

Additional Information

To see the official instruction (CR 5568) go to http://www.cms.hhs.gov/Transmittals/downloads/R1208CP.pdf.

To view the original communication from CMS regarding this issue, go to http://www.cms.hhs.gov/ElectronicBillingEDITrans/downloads/1500%20problems.pdf.

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

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Incomplete or Invalid Claims: Revised Health Insurance Claim Form CMS-1500 (Version 8/05)

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM 5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf.

Provider Action Needed

This article is based on Change Request (CR) 5391 which revises the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the National Provider Identifier (NPI) on the revised Form CMS-1500 version 08/05 and updates the references to remark codes in the instructions and revises the instructions to indicate what is consistent with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Affected providers should assure their billing staff are aware of NPI reporting requirements. These changes apply to claims received on or after May 23, 2007.

Background

The Centers for Medicare & Medicaid Services Form 1500 (CMS-1500; Health Insurance Claim Form) has been revised to accommodate the reporting of the National Provider Identifier (NPI). The revised form is designated as Form CMS-1500 (8/05). The revisions to CMS-1500 include additional items for the reporting of the NPI. The manual revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) through the following Change Requests (CRs):

- CR 4064 at http://www.cms.hhs.gov/Transmittals/Downloads/R777CP.pdf , and MLN Matters article MM 4064 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf ;
- CR 4306 at http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf ;
- CR 4309 at http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf ; and MLN Matters article MM 4309 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf ;
- CR 5079 at http://www.cms.hhs.gov/transmittals/downloads/R1055CP.pdf ; and
- CR 5259 at http://www.cms.hhs.gov/transmittals/downloads/R1034CP.pdf .

As a result of the revisions included in the Form CMS-1500 (8/05), the incomplete and invalid claims instructions are being updated to reflect the appropriate items in which the NPI will be reported.

CR 5391 instructs Medicare contractors (carriers, DMERCs, DME MACs, and A/B MACs):

- To make all necessary changes to their internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the Medicare Claims Processing Manual (Pub. 100-04), Chapter One (Sections 80.3.2.1.1 through 80.3.2.1.3) included as an

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attachment to CR5391, and the Health Care Claim Professional 837 Implementation Guide (http://www.wpc-edi.com/) for further information.

- To use the appropriate remittance advice remark codes provided in the Medicare Claims Processing Manual, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.
- To not search their internal files:
  - To correct a missing or inaccurate NPI on a Form CMS-1500 (8/05) or on an electronic claim.
  - To correct missing or inaccurate information required for HIPAA compliance for claims governed by HIPAA.

Additional Information

For complete details, please see the official instruction at http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf.

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

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Revised Health Insurance Claim Form CMS-1500: Additional Requirements Necessary to Implement

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM 5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf

Key Points

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

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

Background

CMS-1500 claim form is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA),

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and the implementing regulation at 42 CFR 424.32. The CMS-1500 claim form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

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

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

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

Billing Guidelines

- When the NPI number is effective (May 23, 2007, although it can be reported starting January 1, 2007) **and the billed service requires the submission of an NPI,** claims will be **rejected** (in most cases with reason code 16 - "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information, **if**
- The appropriate **NPI is not entered** on CMS-1500 claim form (08-05) in items:
    - **24J** (replacing item 24K, Form CMS-1500 (12-90));
    - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
    - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
    - **33a** (replacing item 33, Form CMS-1500 (12-90)).

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

- Additional NPI-related information can be found at http://www.cms.hhs.gov/NationalProvIdentStand/.

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

- MLN Matters article MM 4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf.

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

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

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

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

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Common Billing Errors to Avoid!

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

Provider Action Needed

This special edition article includes some general information regarding the most frequent errors that are found in claims submitted to Medicare carriers. The article is intended to help you correctly complete your Medicare claims so they will not be denied, rejected, or delayed because of incorrect or incomplete information.

Background

The Administrative Simplification Compliance Act and its implementing regulation (42 CFR 44.32, http://www.gpoaccess.gov/cfr/retrieve.html) require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003 (except from small providers with limited exceptions).

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. A "small provider" is defined in the Federal Register (42 CFR 424.32(d)(1)(vii), http://www.gpoaccess.gov/cfr/retrieve.html). To simplify, Medicare will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 full time employees (FTEs) that bill a Medicare carrier or DMERC to be small. Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

Common Billing Errors

The following list includes common billing errors that you should avoid when submitting your claims to Medicare carriers:

- The patient cannot be identified as a Medicare patient. Always use the Health Insurance Claim Number (HICN) and name as it appears on the patient's Medicare card.
- Item 32 (and the electronic claim equivalent) requires you to indicate the place where the service was rendered to the patient including the name and address –including a valid ZIP code– for all services unless rendered in the patient's home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word "SAME" in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (**NOTE:** *References to an item*

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number, such as item 32, refer to paper claim forms. However, note that whenever an item number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims.)

- The referring/ordering physician's name and UPIN were not present on the claim. Please keep in mind this information is required in Item 17 and 17a on all diagnostic services, including consultations. In addition, be aware of the new requirements for use of National Provider Identifiers (NPIs). To learn more about NPIs and how to obtain your NPI, see the *MLN Matters* article SE 0679 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf on the CMS web site. Also, see the *MLN Matters* articles SE 0555, SE 0659, and MM 4203 for important information regarding CMS' schedule for implementing the NPI. The articles are at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf, http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0659.pdf, **and** http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf, respectively.
- Evaluation and management (E&M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (Example: CPT code 99283, which is an emergency room visit, is submitted with place of service 11, which is office).
- Please keep in mind, when billing services for more than one provider within your group, that you must put the individual provider number in Item 24k, as Item 33 can only accept one individual provider number. Also, please make sure the provider number on the claim is accurate and that it belongs to the group. (Also, remember that as of May 23, 2007, NPIs are to be used.)
- Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.
- Procedure code/modifier was invalid on the date of service. Remember that, as of January 1, 2005, CMS no longer provides a 90-day grace period for billing discontinued CPT/HCPCS codes. (**Note:** *Please read the Medicare provider bulletins, especially at the end of each year, as Medicare lists all the additions, deletions, and code changes for the following year.*)
- Claims are being submitted with deleted procedure codes. This information can also be found in the CPT Book. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

Billing Tips

The following topics will assist you with correct billing and help you complete and submit error free claims:

A. Provider Numbers

Individual vs. Group PIN - Use the individual rendering provider identification number (PIN) on each detail line. Make sure the group number, when applicable, corresponds to the appropriate individual PIN. When a physician has more than one PIN (private practice, hospital, etc.), use the appropriate PIN for the services rendered. A rendering provider number, if not a solo number, must always belong to the group number that is billing. Electronic submitter ID numbers (not UPINs) should be entered in place of the PIN (group or individual). When billing any service to Medicare, if you have doubts as to which provider number to use, please verify with your carrier. (Remember to use NPIs on claims as of May 23, 2007.)

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"Zero-Filling" - Do not substitute zeros or a submitter identification number where a Medicare PIN, UPIN, or NPI is required.

B. Health Insurance Claim (HIC) Numbers

HIC Accuracy – Your carrier receives numerous claims that are submitted with invalid or incorrect HIC numbers. These claims require manual intervention and can sometimes result in beneficiaries receiving incorrect EOMB information. Please be certain the HIC number you are keying is entered correctly, and is also the HIC that belongs to the patient (based on what is on his/her Medicare card) for which you are billing.

HIC Format - A correct HIC number consists of 9 numbers immediately followed by an alpha suffix. Take special care when entering the HIC number for members of the same family who are Medicare beneficiaries. A husband and wife may have a HIC number that share the same Social Security numerics. However, every individual has their own alpha suffix at the end of the HIC number. In order to ensure proper claim payment, it is essential that the correct alpha suffix is appended to each HIC. *No hyphens or dashes should be used.*

"Railroad Retirees" - Railroad Retirement Board (RRB) HIC numbers generally have two alpha characters as a prefix to the number. These claims should be billed to the RRB carrier, at this address:

Palmetto Government Benefit Administrators
Railroad Medicare Services
PO Box 10066
Augusta, GA 30999-0001

C. Name Accuracy

Titles should not be used as part of the name (e.g., Dr., Mr., Rev., M.D., etc.). Be sure to use the name as it appears on the patient's Medicare card.

Non-Medicare Claims - Do not send claims for non-Medicare beneficiaries to your Medicare carrier.

D. Complete Address

U.S. Postal Addressing Standards - It is very important to meet the U.S. Postal addressing standards. Patient and provider information must be correct. This is necessary so that checks and Medicare Summary Notices (MSNs) or remittance notices arrive at the correct destination. It is also to ensure the quickest service to your office.

- A deliverable address may contain both a street name and number or a street name with a Post Office (P.O.) Box number.
- A P.O. Box by itself is acceptable.
- A Rural Route (RR) number must be with a box number. Note: It is incorrect to key P.O. in front of the box number when given with a rural route.

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- A star route number is not a deliverable address. Use highway contract route (HC) instead of star route.
- RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then the box number.
- A box number or a RR number by itself is not deliverable.
- A street name without a number can not be delivered.
- Do not use % or any other symbol when denoting an "in care of" address. C/O is appropriate.
- As always, no commas, hyphens, periods, or other special characters should be used.

Nursing Home or Skilled Nursing Facility Address - For a facility such as a nursing home or skilled nursing facility, it is preferred that a street name and number be supplied. In some cases, this information is not available, but if it is, please use it. Please verify the accuracy of your address before you send this information.

Apartment Complex - An apartment complex (words such as apartments, towers, or complex indicate such) should contain a street address and an apartment number. Again, this information is not always available, but should always be used when it exists.

Development Center / Trailer Park - If a development center or trailer park is given, it should contain the street address and number, if that information is part of the complete address.

"No Street Address" (NSA) - NSA (No Street Address) **is not acceptable**. This is not a deliverable address.

Changes to Provider Address - Please notify your carrier via a CMS-855 form of any address changes for your office practice.

E. Diagnosis and Procedure Codes

Make sure you keep current with valid diagnosis and procedure codes. HIPAA requires that Medicare conform to these standard code sets and reported codes must be valid as of the date of service. Remember that Medicare can no longer allow a grace period for using deleted codes.

Additional Information

Medicare Claims Processing Manual

The *Medicare Claims Processing Manual* (Publication 100-04) contains detailed instructions on Medicare's claims processes and detailed information on preparation and submission of claims. This manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

MLN Matters

MLN Matters is a series of articles that CMS prepares especially for providers. These articles provide information on new and/or deleted procedure and diagnosis codes, changes to the Medicare Physician Fee

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Schedule and other changes that impact physicians and providers. These articles are available at http://www.cms.hhs.gov/MLNMattersArticles/.

Listservs

Listservs are electronic mailing lists that CMS uses to get new information into the hands of physicians and providers as quickly as possible. To get your Medicare news as it happens, join the appropriate listserv(s) at http://www.cms.hhs.gov/apps/mailinglists/.

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

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Palmetto Place

Dr. Hava Question

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

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

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

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Medicare Part B Small Provider Forums

Palmetto GBA is sponsoring General Medicare Part B Seminars designed for small providers. These forums are specifically designed for providers with **fewer than 10 full time employees**. The sessions will include Medicare updates and reimbursement changes and be followed up with question and answer sessions. All specialties are welcome!

Ohio:

Date	Location	Time
Wednesday, June 20, 2007	Highland County District Library 10 Willettsville Pike Hillsboro, OH 45133	9:00 a.m. – 12:00 p.m.
Wednesday, July 18, 2007	South Branch Library 2121 Homewood Drive Lorain, OH 44055	1:00 p.m. – 4:00 p.m.

West Virginia:

Date	Location	Time
Wednesday, July 18, 2007	Days Inn Conference Center 2000 Sutton Lane Sutton, WV 26601	9:00 a.m. – 11:00 a.m.

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

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

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

No Internet access?
If you do not have Internet access, you may register for this event by faxing the registration form on the next page to 614-473-6812. If you have any additional questions, you may contact us at 1-877-567-9232. Select option 3 then option 7.

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Registration Form: Palmetto GBA Small Provider Forums

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

Name: _____

Practice Name: _____

Practice Address: _____

_____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

_____ Wednesday, June 20, 2007, Hillsboro, OH

_____ Wednesday, July 18, 2007, Lorain, OH

_____ Wednesday, July 18, 2007, Sutton, WV

Name and number of persons attending: _____

To Be Completed by Palmetto GBA

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

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

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One-on-One Small Provider Appointments

Palmetto GBA is accepting requests for Medicare Part B One-on-One Small Provider Appointments! This is an excellent opportunity for you to meet with a Community Education Administrator… one-on-one! You may obtain individualized education to address the Medicare concerns your office may have.

Please be sure to submit your request for an appointment **one week** before the date you choose to attend. Complete the Meeting Fax form on the following page and fax the form to 614-473-6812 along with the all topics and questions to be discussed during the appointment. A Palmetto GBA representative will contact you to confirm the time and location of your appointment or to make alternate arrangements.

Ohio:

Date	Location	Time
Wednesday, June 20, 2007	To Be Determined Hillsboro, OH 45133	1:00 p.m. – 4:00 p.m.
Wednesday, July 19, 2007	South Branch Library 2121 Homewood Drive Lorain, OH 44055	1:00 p.m. – 4:00 p.m.

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

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

Meeting Date and Time of Day Requested:

Date	Start Time	End Time
_____	_____	_____

Optional Dates and Times:

Date	Start Time	End Time
_____	_____	_____
_____	_____	_____

Group/Individual Sponsoring Event _____

Contact Person _____ Contact Phone _____ Fax _____

E-mail _____ Registration Web Address _____

Meeting Facility _____

Meeting Facility Address _____

City _____ State _____ Zip Code _____

Facility Phone _____

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

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

_____

_____

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

_____

_____

Requested Agenda Topics

_____

_____

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

Meeting Open _____ Closed _____

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Free Evaluation & Management Medicare Part B Seminars

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

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

Ohio Seminars

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

West Virginia Seminars

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

Registration:

To Register for a seminar go to:

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

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

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

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Psychiatric Services: Regulatory Impact and Medicare Guidelines & Integrating Regulatory Requirements and Good Clinical Practice Workshop

When: Friday, June 8, 2007
Where: Heritage Golf Club, Hilliard
Time: 12 (Noon) - 4 p.m.
CE Credits: 4.0
Registration: http://www.ohpsych.org
Registration Deadline: May 30, 2007

This seminar is sponsored by the Ohio Psychological Association (OPA)
Cost:

- $100 OPA Member
- $125 Non-OPA Member
- $75 Office Staff

Meals: A boxed lunch will be provided.

Palmetto GBA and the Ohio Psychological Association (OPA) are presenting a **Psychiatric Services Seminar** designed for psychologists, psychiatrists and their staff members. Representatives from Palmetto GBA will provide the latest Medicare documentation guidelines for Psychiatric Services.

Don't miss out on this Medicare educational seminar to find out the latest Medicare changes and how they may affect you!

Participants will learn:

- Medicare and Palmetto GBA guidelines regarding psychotherapy, pharmacologic management, neuropsychological and psychological testing
- Special provisions and documentation requirements for services provided in teaching facilities
- Correct documentation through tips and hands-on review of sample progress notes
- How the latest Medicare initiatives affect clinical psychologists

The Integrating Regulatory Requirements and Good Clinical Practice session of the workshop will address the issues facing mental health professionals while balancing clinical decisions and strategies with regulatory mandates.

Participants will learn:

- How to make progress notes clinically meaningful while meeting HIPAA guidelines
- Documentation of medical necessity in progress notes
- Goal setting and documenting progress toward goals while meeting HIPAA and Medicare regulations
- Treatment versus maintenance in psychological interventions with older adults

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EDI Migration to the GPNet Front End

Effective April 2, 2007 to August 1, 2007, Palmetto GBA (OH/WV) will be transitioning from the current RS6000 front end to GPNet, which is located in our corporate office in South Carolina. Although Ohio and West Virginia claims will be submitted through South Carolina, phone support will continue to be provided by the Electronic Data Interchange (EDI) Technical Support team in Ohio. This transition will have an impact on all EDI users including submission of electronic claims, receipt of electronic remittances, receipt of electronic reports, and access to claim status. Our goal is to make the transition of your EDI activities as simple as possible, with minimal disruption to your billing processes.

Advantages of using GPNet are:

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

Important information to know about GPNet submissions is:

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

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

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CPT Modifiers 54 & 55
Date of Service and CPT Codes Must Match

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

• CPT Modifier 54 - for surgical care only

• CPT Modifier 55 - for postoperative management only

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

Appropriate:

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

Inappropriate:

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

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

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

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

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Frequently Asked Question: Medical Review

Can additional testing or treatment be initiated at an initial consultation visit, and have the visit still considered a "consult"?

Answer: A physician or qualified NPP consultant may initiate diagnostic services and treatment at the initial consultation service or subsequent visit. Ongoing management, following the initial consultation service by the consultant, shall not be reported with consultation service codes. These services are reported as subsequent visits for the appropriate place of service and level of service. Payment for a consultation service shall be made regardless of treatment initiation unless a transfer of care occurs.

Resources:
http://www.cms.hhs.gov/manuals
Internet-Only Manual Publication # 100-04, Chapter 12, Section 30.6.10

Do I need to send documentation for Prolonged Care code with each claim?

Answer: Documentation is not required to accompany claims for prolonged services. Documentation is required in the medical record to indicate the duration and content of the evaluation and management code submitted and must show that the physician personally furnished the time specified in the CPT code definition. This documentation must be available and provided to Palmetto GBA upon request.

Resources:
http://www.cms.hhs.gov/manuals
Internet-Only Manual Publication # 100-04, Chapter 12, Section 30.6.15.1

If a provider sees a new patient and a comprehensive history is performed, does the comprehensive history warrant submitting a higher level service?

Answer: Because the level of E/M service is dependent on three key components (History, Examination, and Medical Decision Making), performance and documentation of one component (e.g., history) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

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

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National Provider Identifier (NPI) Usage: Importance Guidance

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

Provider Action Needed

Impact to You

You must report your NPI correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone Interactive Voice Response (IVR) queries by no later than May 23, 2007, or your transactions will be rejected.

What You Need to Know

Carriers have reported errors on claims (see Background, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

What You Need to Do

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

Background

All HIPAA covered healthcare providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment must obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as healthcare providers, healthcare clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits healthcare plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes. Medicare will also require NPIs for

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identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in Interactive Voice Response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their National Supplier Clearinghouse (NSC) number or their NPI to identify themselves, and either the Unique Provider Identification Number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007 and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007, that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837–I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Some of the errors seen by Medicare carriers include the following:

Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims

Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the Provider Identification Number (PIN) or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain. If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

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To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop
Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I(Institutional) Electronic Claim
FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim. The facility that furnished the care, or the established owner of that facility, must have indicated on their 855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent 855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

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Additional Information

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007.

Note: Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier. Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.
- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.

Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

You can find more information about the National Provider Identifier (NPI) by going to the NPI page at http://www.cms.hhs.gov/apps/npi/01_overview.asp.

In addition, if you have any questions on the NPI, you may call our office at 1-877-567-9232.

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National Provider Identifier (NPI) Enumerator Contractor: Information on Obtaining NPIs

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

Provider Action Needed

Learn about the NPI and how and when to apply for one.

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

Important Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

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NPI Enumerator Contract Awarded

Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI.

Note: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

The NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The Web address will be https://nppes.cms.hhs.gov/NPPES/Welcome.do, but please note -- the Web site is not available until May 23, 2005.
2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on https://nppes.cms.hhs.gov/NPPES/Welcome.do or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. But remember, paper applications may not be submitted until July 1, 2005.
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. This process will be available in the fall of 2005.

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The

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paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

Additional Information

For additional information on NPIs:

- Visit http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp.
- Beginning May 23, 2005, visit https://nppes.cms.hhs.gov/NPPES/Welcome.do or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA Hotline: 1-866-282-0659, or write to AskHIPAA@cms.hhs.gov.

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National Provider Identifier (NPI) Editing Requirements: Change Request 4023 and Attachment for Change Request 4320

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

Provider Action Needed

Impact to You

This article is based on CR 5229, which corrects certain business requirements from CR 4023 that relate to edits for National Provider Identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006, and later. Additionally, CR 5229 revises Attachment 1 to CR 4320.

What You Need to Know

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR 5229 modifies those business requirements.

What You Need to Do

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the *Background* section of this article and to CR 5229 for additional important information regarding these modifications.

Background

The Medicare Learning Network (MLN) articles, MM 4023 and MM 4320 which are based on CR 4023 and CR 4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the *Additional Information* section of this article.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414). To comply with this requirement, The Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs on May 23, 2005. Applications can be made by mail and online at https://nppes.cms.hhs.gov.

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CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

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

TTY 1-877-391-9739

Provider Enrollment Support Line
1-866-308-5439

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

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
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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/

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