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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

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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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Beginning June 2, 2008: New Telephone Number for CSR Calls

To better serve you, the OH/WV Part B Provider Contact Center will have separate phone numbers to reach our Interactive Voice Response (IVR) system and our Customer Service Representatives (CSR) beginning on Monday, June 2, 2008. Making this change will allow us to add more incoming lines.

You will be able to call our IVR only line between the hours of 6:00 a.m. - 9:00 p.m. to obtain:

- Beneficiary eligibility
- Claim status
- Deductible information
- Number of claims and dollar amount pending payment
- A duplicate remittance notice
- Pricing information
- Breaking Medicare news
- Guidance on appealing a denied claim
- Steps to request a Provider Outreach and Education meeting or seminar

Customer Service Representatives will continue to be available between the hours of 8:30 a.m. - 4:30 p.m. Monday through Friday on a separate CSR only toll free line to assist you with more complex or non-routine inquiries.

The IVR Only phone number will continue to be 1-877-567-9232. The new CSR Only phone number is 1-866-332-7025 and will be available beginning on June 2nd.

The Centers for Medicare & Medicaid Services (CMS) advises provider contractors in Publication 100-09 (Medicare Contractor Beneficiary and Provider Communications Manual) Chapter 6, Section 50.1, that *“If a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information can be found on the IVR, the inquirer shall be directed to the IVR. If at any time during a telephone inquiry the inquirer requests information that can be found on the IVR, the CSR shall refer the inquirer back to the IVR...”* Palmetto GBA will continue to ensure that these routine inquiries are handled through the IVR, which will allow representatives to be available to handle more difficult or complex issues.

Changes effective June 2, 2008

- IVR ONLY: call 1-877-567-9232
- CSR ONLY: call 1-866-332-7025

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Telephone Reopening Line

Providers and Beneficiaries may request to have their Medicare claim reopened over the telephone. A claim can be reopened to correct minor errors or omissions by calling our toll free line at **1-866-308-5441** Monday through Friday from **9:00 AM to 12:00 PM and from 1:00 PM to 3:00 PM (EST)**. A maximum of three (3) requests can be handled during the same phone call.

We will not be able to assist you on this line for the following issues: status of claims, why a claim has been denied, issues that require additional documentation, unprocessable claims (MA130 – this will appear on the top line of the patient’s account on your remittance advice toward the right hand side of the page). Please contact our Provider Contact Center at the number below for assistance with these issues.

Please be aware that the following information will be needed in order for your claim to be reopened and must match exactly to Medicare’s files:

- The provider’s/physician’s/supplier’s name, Provider Transaction Access Number (PTAN) and NPI;
- Beneficiary last name, first initial; and
- Health Insurance Claim Number (HICN)

The following types of claims can be reopened at the carrier’s discretion:

- Mathematical or computational mistakes;
 - If you submitted the incorrect number of units (i.e. 1 unit instead of 10 units in item 24G or its electronic equivalent), please be sure to adjust the billed amount, if necessary.
- Transposed procedure or diagnosis codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer errors;
- Duplicate denials, when you believe that the “duplicate” denial is incorrect (i.e. two (2) ambulance transports same modifiers on both transports but at different times of day)
- Incorrect data items, such as rendering provider within same group, date of service (month and day only – unable to change the year of service)
- Adding and/or removing of modifiers from procedure codes that do not require additional documentation.

The above list is not an all inclusive list. If your issue is not listed above you may access the IVR line at 1-877-567-9232 for general information about your claim and its status. For complex inquiries about your claim, you may contact a Customer Service Representative at 1-866-332-7025. You can also find more information concerning the appeals process on the internet at:

Ohio: <http://www.PalmettoGBA.com/boh/appeals>

West Virginia: <http://www.PalmettoGBA.com/bwv/appeals>

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CMS Claim Filing Instructions

Important Changes-New Information on Dot Matrix Printers and Item 21

The following instructions have been developed as a guide for submitting the CMS-1500 Claim Form to Palmetto GBA. It is intended to serve as a useful supplement to other articles that have been published by Palmetto GBA. Please see the Web sites listed at the end of this article for additional submission instructions.

Dot Matrix Printers

Palmetto GBA will no longer accept paper claims printed on dot matrix printers. Paper claims are scanned and electronically entered into our processing system, and dot matrix printers produce type that is very light, which causes delays in processing your claims.

Even if you qualify to submit paper claims, **consider submitting electronically**. Electronic claims are processed more quickly, and you will generally receive reimbursement sooner than if you submit paper claims. Please contact the EDI Technical Support Team at 1-866-308-5438 for more information.

Why use the CMS-1500 Claim Form?

The CMS-1500 claim form answers the needs of many insurers. It is the basic form prescribed by the Centers of Medicare & Medicaid Services (CMS) for the Medicare program for claims from physicians and suppliers.

The revised version of the form is Form CMS-1500 (08/05) and is approved under the OMB collection 0938-0999. The current form has been revised to accommodate the implementation of the National Provider Identifier (NPI). All claims must be submitted using the Form CMS-1500 (08-05).

Reminder: The Administrative Simplification and Compliance Act (ASCA) prohibits Medicare from making payments on claims not submitted electronically on or after October 16, 2003, unless a provider is small (fewer than 10 full-time equivalent employees for providers required to bill Medicare carriers), or meets one of the very few limited exceptions to this requirement.

You must submit your claims electronically unless you meet the exceptions criteria established by ASCA.

If you qualify to submit paper claims, follow these instructions when completing your CMS-1500 forms:

Preparing the CMS-1500 Claim Form

Palmetto GBA uses an Optical Character Recognition (OCR) system to enter claim information from the CMS-1500 claim form into the processing system. In addition, OCR minimizes the manual intervention required to correctly process your Medicare Part B claims. Successful scanning begins with the proper submission of claim data. It is important that claims be submitted with proper and legible coding. Claims that are not legible or properly coded will be returned or rejected.

Please follow these helpful hints when completing your CMS-1500 forms:

The font should be:

- Legible (computerized or typed claims, laser printers are recommended)
- In Black Ink

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- Courier or Arial in 10, 11 or 12 point font
- CAPITAL letters

The font must NOT have:

- Dot matrix print (**Claims processed on dot matrix printers through OCR, compromise accurate information and clarity. Palmetto GBA has chosen to no longer accept claims processed on Dot Matrix Printers.**)
- Bold, Script, Italic or Stylized font
- Broken characters
- Red Ink
- Mini-font

Do NOT submit paper claims with:

- Liquid correction fluid changes
- Data touching box edges or data running outside of the numbered boxes
- More than six service lines per CMS-1500 claim form. Do not compress two lines of information on one line. If more than six service lines are required see instructions listed below under **“Claims Submitted with Multiple Pages.”**
- Information in the shaded area in 24a through 24h. These fields are not used by Medicare (exception- NDC for physician-administered drugs for Medicare/Medicaid patients).
- Narrative descriptions of procedure codes, modifiers or diagnosis codes
- Stickers or rubber stamps
- Data, mailing address or labels on the top portion of the CMS-1500 claim form
- Special characters (e.g., hyphens, periods, parentheses, dollar signs and ditto marks)
- Handwritten descriptions
- Superbills

The claim form must be:

- An original CMS-1500 printed in red “drop out” ink with the printed information on back. Photocopies are not acceptable.
- Size- 8 ½ x 11” with the printer pin-feed edges removed at the perforations
- Free from excessive creases or tears (do not fold or staple)
- Clean and free from stains, notations, strike-overs, crossed-out or highlighted information, liquid correction fluid, glue or tape

Attachment Reminders:

- All attachments must identify the patient’s name, Health Insurance Claim number, date of service and other pertinent information
- Attachments must be a full page (8 ½ x 11”)
- Operative reports, radiology reports, etc. should be submitted with paper claims only when either the coding guidelines indicate these reports are needed to process the service(s) or when a Medicare representative requests this additional information.
- **Medicare Secondary Paper claims:** Only attach the summary notice from the primary insurer that specifically corresponds to the claim you are submitting.

Internet Resources:

Interactive CMS-1500 Claim Form Instructions

- Ohio: <http://www.PalmettoGBA.com/boh/Guide>
- West Virginia: <http://www.PalmettoGBA.com/bwv/Guide>

Claims submitted with Multiple Pages

DO NOT complete Item 28 for each CMS-1500 claim form. The total for Item 28 must be completed on the last CMS-1500 claim form. This only applies when there are more than six detail lines for one claim.

If multiple CMS-1500 claim forms are submitted with totals on each claim form, the claims will be scanned as separate claims and not as multi-page claims.

| ITEM | INFORMATION |
|------|---|
| 1 | MEDICARE: Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box. |
| 1a | INSURED'S I.D. NUMBER: Enter the patient's Medicare Health Insurance Claim Number (HICN), whether Medicare is primary or secondary payer. |
| 2 | PATIENT'S NAME: Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. |
| 3 | PATIENT'S BIRTH DATE: Enter the patient's 8-digit birth date (MM/DD/CCYY) and sex. |
| 4 | INSURED'S NAME: If there is insurance primary to Medicare, either through the patient or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank. |
| 5 | PATIENT'S ADDRESS: Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number. |
| 6 | PATIENT'S RELATIONSHIP TO INSURED: Check the appropriate box to indicate the patient's relationship to the insured when Item 4 is completed. |
| 7 | INSURED'S ADDRESS: Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this Item only when Items 4, 6 and 11 are completed. |
| 8 | PATIENT STATUS: Check the appropriate box for the patient's marital status and whether employed or a student. |
| 9 | OTHER INSURED'S NAME: Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in Item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. |

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| | <p>Note: Only participating physicians and suppliers are to complete Item 9 and its subdivisions, and only when the patient wishes to assign his/her benefits under a Medigap policy to the participating physician or supplier.</p> <p>Participating physicians and suppliers must enter information required in Item 9 and its subdivision if requested by the patient. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a patient elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See Pub. 100-04, Chapter 28 of the <i>Internet Only Manual</i> [IOM].)</p> <p>Medigap: A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in Section 1882 (g) (1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation, which is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.</p> <p>Do not list other supplemental coverage in Item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.</p> |
| 9a | <p>OTHER INSURED'S POLICY OR GROUP NUMBER: Enter the policy and/or group number of the Medigap enrollee preceded by MEDIGAP, MG, or MGAP.</p> <p>NOTE: Item 9d must be completed if you enter a policy and/or group number in Item 9a.</p> |
| 9b | <p>OTHER INSURED'S DATE OF BIRTH: Enter the Medigap insured's 8-digit birth date (MM/DD/CCYY) and sex.</p> |
| 9c | <p>EMPLOYER'S NAME OR SCHOOL NAME: Disregard the "Employer's Name or School Name" which is printed on the form. Enter the claims processing address or the Medigap insurer. Use the abbreviated street address, two letter State postal code, and zip code copied from the Medigap enrollee's Medigap identification card. For example:</p> <p>1257 Anywhere Street Baltimore, Maryland 21204</p> |

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| | <p>is shown as "1257 Anywhere St. Baltimore, MD 21204"</p> <p>Note: If a carrier assigned unique physician identifier of a Medigap insurer appears in Item 9d, Item 9c may be left blank.</p> |
| 9d | <p>INSURANCE PLAN NAME OR PROGRAM NAME: Enter the name of the Medigap enrollee's insurance company or the Medigap insurer's unique identifier provided by the local Medicare carrier.</p> <p>If the patient wants Medicare payment data forwarded to a Medigap insurer through the Medigap claim-based crossover process, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d.</p> <p><i>A Medicare participating provider or supplier shall only enter the COBA Medigap claim based ID within item 9d when seeking to have the patient's claim crossed over to a Medigap insurer. If a participating provider or supplier enters the PAYERID or the Medigap insurer program or its plan name within item 9d, the Medicare Part B contractor or Durable Medical Equipment Medicare Administrative Contractor (DMAC) will be unable to forward the claim information to the Medigap insurer prior to October 1, 2007, or to the Coordination of Benefits Contractor (COBC) for transfer to the Medicare insurer on or after October 1, 2007. (See chapter 28 §70.6.4 for more information concerning the COBA Medigap claim-based crossover process.)</i></p> <p><i>A list of Medigap insurers may be found on CMS' Web site at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf</i></p> |
| 10a-10c | <p>IS THE PATIENT'S CONDITION RELATED TO: Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24. Enter the State postal code. Any items checked "YES," indicates there may be other insurance primary to Medicare. Identify primary insurance information in Item 11.</p> |
| 10d | <p>RESERVED FOR LOCAL USE: Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.</p> <p><i>Currently, Palmetto GBA receives an eligibility tape from Medicaid. This procedure will continue and this will not be a required item at this time.</i></p> |
| 11 | <p>INSURED'S POLICY GROUP OR FECA NUMBER: This item must be completed. By completing this item, the physician/supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer.</p> <p>Important: This item must NOT be left blank or the claim will be rejected.</p> <ul style="list-style-type: none"> • If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11a-11c. Items 4, 6 and 7 must also be completed. • Note: Enter the appropriate information in Item 11c if insurance primary to Medicare |

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| | <p>is indicated in Item 11.</p> <ul style="list-style-type: none"> • If there is NO insurance primary to Medicare, enter the word "NONE" and proceed to Item 12. • If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to Item 11b. • If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly. • Insurance primary to Medicare: Circumstances under which Medicare payment may be secondary to other insurance include: <ul style="list-style-type: none"> - Group Health Plan coverage: <ul style="list-style-type: none"> ▪ Working Aged ▪ Disability (large group health plan) ▪ End stage renal disease - No fault and/or other liability - Work-related illness/injury <ul style="list-style-type: none"> ▪ Workers' Compensation ▪ Black Lung ▪ Veterans Benefits <p>NOTE: For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Chapter 3, <i>Medicare Secondary Payer Manual</i>.)</p> |
| 11a | INSURED'S DATE OF BIRTH: Enter the insured's 8-digit birth date (MM/DD/CCYY) and sex if different from Item 3. |
| 11b | EMPLOYER'S NAME OR SCHOOL NAME: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) retirement date preceded by the word "RETIRED." |
| 11c | INSURANCE PLAN NAME OR PROGRAM NAME: Enter the 9-digit PAYERID number for the primary insurer. If no PAYERID exists, then complete insurance primary payer's program or plan name (e.g., Blue Shield of (State)). If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in Item 11. |
| 11d | IS THERE ANOTHER HEALTH BENEFIT PLAN?: Leave blank. Not required by Medicare. |
| 12 | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: |

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| | <p>The patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alphanumeric date (e.g., January 1, 2007) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." If the patient is physically or mentally unable to sign, a representative as specified in Pub. 100-4, Chapter 1, "General Billing Requirements," may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.</p> <p>The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment of the claim.</p> <p>Signature by mark (X): When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.</p> |
| 13 | <p>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in Item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider or service or supplier's office must be insurer specific. It may state that the authorization applies to all services until it is revoked.</p> |
| 14 | <p>DATE OF CURRENT: Enter either an 8-digit (MM DD CCYY) or 6-digit (MM DD YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM DD CCYY) or 6-digit (MM DD YY) date of the initiation of the course of treatment and enter an 8-digit (MM DD CCYY) or 6-digit (MM DD YY) date of the X-ray to document subluxation in item 19.</p> |
| 15 | <p>IF THE PATIENT HAS HAD SAME OR SIMILAR SERVICES ILLNESS GIVE FIRST DATE: Leave blank. Not required by Medicare.</p> |
| 16 | <p>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM DD CCYY) or 6-digit (MM DD YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.</p> |
| 17 | <p>NAME OR REFERRING PHYSICIAN OR OTHER SOURCE: Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.</p> <p>The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to: 1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery</p> |

- by the State in which he/she performs such function or action;
- 2) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
 - 3) A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;
 - 4) A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or
 - 5) A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with

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| | <p>in-office clinical laboratory tests);</p> <ul style="list-style-type: none"> • When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17; • When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner; |
| 17a | <p>I.D. NUMBER OF REFERRING PHYSICIAN: Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17. The UPIN may be reported on the Form CMS-1500, and MUST be reported if an NPI is not available.</p> <p>NOTE: Field 17a and/or 17b is required when a service was ordered or referred by a physician.</p> <p>When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.</p> |
| 17b | <p>NPI Number of Referring Physician: Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available.</p> <p>NOTE: Field 17a and/or 17b is required when a service was ordered or referred by a physician.</p> |
| 18 | <p>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: Enter either an 8-digit (MM DD CCYY) or a 6-digit (MM DD YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.</p> |
| 19 | <p>RESERVED FOR LOCAL USE: Enter either a 6-digit (MM DD YY) or an 8-digit (MM DD CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.</p> <p>For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24K of this section.</p> <p>Enter either a 6-digit (MM DD YY) or an 8-digit (MM DD CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to</p> |

demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

CPT modifier 99 is only appropriate when more than four modifiers are necessary per line item. When only four modifiers apply, enter each modifier in the existing space in Item 24D.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed. ***Note: A dental exam is covered for limited services when it is part of a comprehensive evaluation and management service.***

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care. ***Note:***

| | |
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| | <p><i>The physician billing CPT modifier 54 will indicate the relinquished date of care and responsibility. The provider billing CPT modifier 55 will indicate the date the post-operative care and responsibility is assumed.</i></p> <p>Enter demonstration ID number "30" for all national emphysema treatment trial claims. You may voluntarily report the 8-digit National Library of Medicine (NLM) Clinical Trials Data Bank number for items and services provided in clinical trials that are qualified for coverage. The NLM number is not required at this time. Report this number with a "CT" prefix in Item 19 for paper claims only. For example: CT12345678.</p> <p>Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)</p> <p><i>Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point[xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.</i></p> <p><i>Unless indicated on the previous pages, no other documentation is to be entered in Item 19 of the CMS-1500 claim form. Only the information, as listed on the previous pages, will be accepted in Item 19. Claims will be rejected if above instructions are not followed.</i></p> |
| 20 | <p>OUTSIDE LAB? -\$CHARGES:</p> <p>Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed.</p> <p>When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500.</p> <p>NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.</p> |
| 21 | <p>DIAGNOSIS OR NATURE OR ILLNESS OR INJURY:</p> <p>Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses codes.</p> <p>Providers that need to submit more than four diagnosis codes must file the claim electronically.</p> <p>All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.</p> |

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| | Only ICD-9-CM code numbers should be listed in Item 21. Narrative descriptions/diagnoses could cause the claim to deny. |
| 22 | MEDICAID RESUBMISSION CODE: Leave blank. Not required by Medicare. |
| 23 | PRIOR AUTHORIZATION NUMBER: Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval. Enter the 7-digit Investigational Device Exemption (IDE) number when an investigational device is used in a FDA-approved clinical trial. For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI when effective) of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed. Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures. Ambulance providers must enter the five-digit zip code for the point of pickup. |
| 24 | The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. At this time, the shaded area <i>in 24a through 24h</i> is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims. <i>When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g., N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space fill the remaining positions (e.g., UN2 or F2999999). This information is only needed when:</i> <ul style="list-style-type: none"> • <i>Submitting paper claims.</i> • <i>The claims is being submitted to Medicare for patients eligible for both Medicare & Medicaid</i> • <i>The data would only be passed to Medicaid through the COB process. Medicare will not edit, validate, or process the NDCs and corresponding quantities received.</i> |
| 24A | DATE(s) OF SERVICE: Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days |

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| | or units in column 24G. |
| 24B | <p>PLACE OF SERVICE: Enter the appropriate place of service code(s) from the list provided in Pub. 100-4, Chapter 26, Section 10.5. Identify the location, using a place of service code, for each item used or service performed.</p> <p>NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.</p> |
| 24C | <p>TYPE OF SERVICE: Medicare providers are not required to complete this item.</p> |
| 24D | <p>PROCEDURES, SERVICES, OR SUPPLIES: Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers. Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim.</p> |
| 24E | <p>DIAGNOSIS CODE: Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service. Enter 1, 2, 3, 4, 5, 6, 7 or 8.</p> <p>If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.</p> |
| 24F | <p>CHARGES: Enter the charge for each listed service.</p> |
| 24G | <p>DAYS OR UNITS: Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.</p> <p>Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.</p> <p>For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.</p> <p>For instructions on submitting units for oxygen claims, see Pub. 100-4, Chapter 20, Section 130.6.</p> |
| 24H | <p>EPSDT FAMILY PLAN: Leave blank. Not required by Medicare.</p> |

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| 24I | <p>Legacy Qualifier Rendering Provider: Enter the ID qualifier 1C in the shaded portion.</p> |
| 24J | <p>Legacy Provider Number(PTAN)/NPI Rendering Provider: Enter the rendering provider’s PIN(PTAN) in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.</p> <p>Enter the rendering provider’s NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.</p> |
| 24K | <p>RESERVED FOR LOCAL USE: There is no Item 24K on this version.</p> |
| 25 | <p>FEDERAL TAX I.D. NUMBER: Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number.</p> |
| 26 | <p>PATIENT'S ACCOUNT NUMBER: Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist you in patient identification.</p> |
| 27 | <p>ACCEPT ASSIGNMENT: Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.</p> <p>The following providers of service/suppliers and claims can only be paid on an assignment basis:</p> <ul style="list-style-type: none"> • Clinical diagnostic laboratory services; • Physician services to individuals dually entitled to Medicare and Medicaid; • Participating physician/supplier services; • Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers; • Ambulatory surgical center services for covered ASC procedures; • Home dialysis supplies and equipment paid under Method II; • Ambulance services; • Drugs and biologicals; and • Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine. |
| 28 | <p>TOTAL CHARGES: Enter total charges for the services (i.e., total of all charges in item 24f).</p> |
| 29 | <p>AMOUNT PAID:</p> |

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| | Enter the total amount the patient paid on the covered services only. |
| 30 | BALANCE DUE: Leave blank. Not required by Medicare. |
| 31 | SIGNATURE OF PHYSICIAN OR SUPPLIER: Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM DD YY), 8-digit date (MM DD CCYY), or alpha-numeric date (e.g., January 1, 2007) the form was signed. In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31. |
| 32 | NAME AND COMPLETE ADDRESS OF FACILITY (INCLUDING ZIP CODE) WHERE SERVICES WERE RENDERED: Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, <i>enter</i> the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. NOTE: A PO Box is not an acceptable address. Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code. If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home. If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number. Complete this item for all laboratory work performed outside a physician's office. If an |

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| | independent laboratory is billing, enter the place where the test was performed. |
| 32a | Facility NPI Number Enter the NPI of the service facility. Providers of service (namely physicians) shall identify the supplier's NPI when billing for purchased diagnostic tests. |
| 32b | Facility Qualifier and Legacy Number Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests. |
| 33 | PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE#: Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. |
| 33a | Billing Provider NPI Number Enter the NPI of the billing provider or group. |
| 33b | Billing Provider Qualifier and Legacy Number Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. |

National Provider Identifier (NPI): Audiologist Claims

IMPORTANT - Delay of Enrollment Requirement for Audiologists

On February 29, 2008, the Centers for Medicare and Medicaid Services (CMS) issued Change Request 5717 titled “Update to Audiology Policies”. Transmittal 1470 of that change request provided clarifications to the Medicare Claims Processing Manual (Pub. 100-04). In Pub 100-04, Chapter 12, Section 30.3, the manual instructions state, “. . . the audiologist’s NPI is required on all claims for services furnished by audiologists.” Use of the NPI in the primary identifier field on a claim requires Medicare enrollment.

Note that CMS is instructing contractors to, prior to October 1, 2008, continue to process claims without the NPI of the audiologist. All other instructions in Change Request 5717 remain unchanged.

CMS will require the use of the NPI on claims for diagnostic test services furnished by audiologists on or after October 1, 2008. Audiologists are encouraged to obtain an NPI and enroll as soon as possible.

Provider Authentication: Medicare Provider Contact Centers

Provider Types Affected

Physicians, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors, (DME MAC)) for services provided to Medicare Beneficiaries.

What You Need to Know

SE 0814 covers the implementation of the National Provider Identifier (NPI) and the Provider Transaction Access Number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

Note: For providers enrolled in Medicare before May 23, 2008, their PTAN initially will be their legacy provider number. New providers enrolling in Medicare on or after May 23, 2008, will be assigned a PTAN as part of the Medicare enrollment process.

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 provider contact centers (PCC) must properly authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

Please refer to the Medicare Contractor Beneficiary and Provider Communications Manual (Publication 100-9), chapter 3, section 30 and chapter 6, section 80 for a complete discussion of this PCC authentication update. You can find these manual sections at <http://www.cms.hhs.gov/manuals/downloads/com109c03.pdf> and <http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf>.

Provider Authentication

The elements for provider authentication of telephone (either Customer Service Representative (CSR) or Interactive Voice Response (IVR)) and written inquiries are presented in the table below.

Provider Authentication Elements for Telephone & Written Inquiries:

| Effective Dates | Inquiry Type | Provider Elements to be Authenticated (all elements must match unless otherwise specified) |
|--------------------------|--------------|---|
| On or after May 23, 2008 | IVR | Provider NPI & PTAN |
| On or after May 23, 2008 | CSR | Provider NPI & PTAN |

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| Effective Dates | Inquiry Type | Provider Elements to be Authenticated (all elements must match unless otherwise specified) |
|--------------------------|--------------------------------|---|
| On or after May 23, 2008 | Written, including fax & email | Provider name & either provider NPI or PTAN |

Written Inquiries – Exception to above authentication requirements:

CMS allows an exception for written or faxed inquiries submitted on a provider’s official letterhead, and e-mail inquiries (with an attachment on letterhead). If the provider’s name and address are included in the letterhead and clearly establish the provider’s identity, no NPI or PTAN is required for authentication.

Additional Information

If you have any questions, please contact our office at 1-866-332-7025.

Assignment of Providers to Medicare Administrative Contractors

Provider Types Affected

All physicians, providers and suppliers who submit claims to Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), carriers or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers

This “One Time Notice” CR describes the Centers for Medicare & Medicaid Services (CMS) approach for assigning providers to MACs and discusses the process of moving providers to MACs.

Background

This article is based on CR 5979 and Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, amended Title XVIII of the Social Security Act (the Act) to add section 1874A, Contracts with Medicare Administrative Contractors (MACs).

I. What are “MACs?”

Under section 911 of the MMA, Congress requires that CMS replace the current fiscal intermediary (FI) and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation (FAR). Under the new Medicare Administrative Contractor (MAC) contracting authority, CMS has 6 years - between 2005 and 2011 - to complete the transition of Medicare Fee-for-Service (FFS) claims processing activities from the FIs and carriers to the MACs.

For information on CMS’ progress in awarding and implementing the MACs, please visit <http://www.cms.hhs.gov/MedicareContractingReform/>.

II. What is “Provider Nomination?”

“Provider Nomination” is a phrase that describes the former right of an individual provider or a chain of providers to select assignment to the FI of its choice. In section 911(b) of the MMA, Congress repealed the provider nomination provisions of the Social Security Act. Provider nomination has been replaced with the geographic assignment rule. Generally, a provider will be assigned to the MAC that covers the state where the provider is located. The CMS regulation at 42 CFR 421.404 reflects this policy shift. Other CMS regulations and policy manuals are in the process of being updated.

A moratorium was placed on the “change of intermediary” process for individual providers in October of 2005. Transmittal 291 (CR # 5720), dated September 19, 2007, (<http://www.cms.hhs.gov/Transmittals/downloads/R291OTN.pdf>) informed all FIs and A/B MACs that CMS would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There remains one exception for qualified chain providers (QCPs) as discussed in Section V below.

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III. Where will providers eventually be assigned in the MAC environment?

A. Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located. See the following link for a description of the MAC-environment HH&H regions and the four MACs that will administer HH&H claims for those four regions.

http://www.cms.hhs.gov/MedicareContractingReform/06_SpecialtyMACJurisdictions.asp#TopOfPage

B. Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides. The link above under “A” also provides a description of the MAC-environment DMEPOS regions and the four MACs that will administer DMEPOS claims for those four regions.

C. Qualified Railroad Retirement Beneficiaries Entitled to Medicare

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

D. Specialty Providers and Demonstrations

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. A list of those specialty services and their designated MACs is reflected in the following table:

MACs Designated to Process Specialty or Demonstration Claims

| Specialty Service or Demonstration | MAC Jurisdiction |
|--|-------------------------|
| Centralized Billing for Mass Immunizers | 4 |
| Indian Health Services | 4 |
| Low Vision Demonstration | 5,10, 11, 13, and 14 |
| Rural Community Hospital Demonstration | 1, 2, 4 and 5 |
| Veterans Affairs Medicare Equivalent Remittance Advice Project | 4 |
| Chiropractic Services Demonstration | 4 and 5 |
| Home Health Third Party Liability Demonstration Project | 14 |
| Medicare Adult Day Care Demonstration | 11, 14 and 15 |

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| Specialty Service or Demonstration | MAC Jurisdiction |
|---|-------------------------|
| Independent Organ Procurement Organizations | 10 |
| Religious Non-medical Health Care Institution (RNHCI) | 10 |
| Histocompatibility Lab | 10 |

The following material describes the demonstrations and specialty providers listed above. Generally, a provider will already know whether or not it is participating in one of these categories.

Centralized Billing for Mass Immunizers - In order to encourage providers to supply flu and pneumococcal (PPV) vaccinations to Medicare beneficiaries, CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type “Mass Immunizer,” as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered and the carrier must make payment based on the payment locality where the service was provided. IOM Pub. 100-04, Chapter 18, Sections 10.3 and 10.3.1 provide more specific information related to this activity.

Indian Health Services - The Indian Health Service (IHS) is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes living on or near reservations. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals (including CAHs), freestanding clinics, FQHCs, RHCs and other entities.

While §§1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, passage of the Indian Health Care Improvement Act (IHCIA) in 1976 provided for an exception, amending §1880 of the Act, for facilities of the IHS whether operated by such Service or by an Indian tribe or tribal organization (as defined in section 4 of the IHCIA). The exception under § 1880 limited payment to Medicare services provided in hospitals and skilled nursing facilities.

Effective July 1, 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), §432 extended payment on a fee-for-service (FFS) basis to services of physician and non-physician practitioners furnished in IHS hospitals and freestanding clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and/or operated by IHS are authorized to bill only the Jurisdiction 4 MAC. Additionally, Tribal health facilities operated under Indian Self Determination Education and Assistance Act (ISDEAA) authorities are an extension of the IHS and considered facilities

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of the IHS. By virtue of this, they are authorized to bill the Jurisdiction 4 MAC. ISDEAA authorities provide flexibilities to tribes in the administration of their programs that are not provided to general public providers.

Low Vision Demonstration - 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.

This demonstration will last for five (5) 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.

Rural Community Hospital Association - The RCH Demonstration Program was mandated by section 410A of the MMA. The Secretary is required to conduct the RCH Demonstration, lasting five (5) years, to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. This Demonstration will allow selected rural hospitals to benefit from cost-based reimbursement for inpatient services.

The Secretary is required to select not more than fifteen (15) hospitals to participate in the demonstration in States with low population densities. Currently, thirteen (13) hospitals participate in the program, serviced by seven different Fiscal Intermediaries (FIs).

Veteran Affairs Medicare Equivalent Remittance Advice Project - Current law permits the Department of VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished:

- At VA facilities; and
- For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance.

To facilitate this process, the Centers for Medicare & Medicaid Services (CMS) entered into an interagency agreement with the VA whereby the CMS will help the VA work with a CMS contractor to adjudicate these claims to produce a remittance advice equivalent to that ordinarily produced for Medicare claims. The remittance advice, sent to the supplemental insurers, will help the insurers determine payment amounts

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they owe to the VA. The CMS will not pay these claims. Trailblazer was the contractor selected to perform the work.

Chiropractic Services Demonstration - Section 651 of the MMA requires the Centers for Medicare & Medicaid Services (CMS) to conduct the Expansion of Coverage for Chiropractic Services Demonstration. The purpose of the demonstration is to evaluate the feasibility and advisability of expanding coverage of chiropractic services under Medicare. The demonstration is for two years and must be conducted in four geographic areas—two rural and two urban.

Home Health Third Party Liability Demonstration - The CMS and the States of Connecticut, Massachusetts, and New York have developed a demonstration program that will use a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were submitted to and paid by the Medicaid agencies. Sampling will be used in lieu of individually gathering Medicare claims from home health agencies (HHAs) for every dual eligible Medicaid claim each State may have paid in error. This process will eliminate the need for the HHAs to assemble, copy, and submit large numbers of medical records. The project currently covers the home health claims incurred in fiscal years (FY) 2000 through 2007 for Massachusetts and New York and FY 2001 through 2005 for Connecticut.

Medicare Adult Day Care Demonstration - Section 703 of the MMA directs CMS to conduct a demonstration project that will test an alternative approach to the delivery of Medicare home health services. Under this demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. The statute requires the demonstration to run for a period of three (3) years at no more than five (5) HHA sites in states that license certified medical adult day care facilities.

Implementation of the demonstration began at five (5) sites on August 1, 2006. Participation of Medicare beneficiaries is voluntary; up to 15,000 beneficiaries at any time will be eligible to enroll in the three (3)-year demonstration.

Medicare Home Health Agency Provider Enrollment Demonstration - This demonstration is designed to combat fraudulent home health activity in the Houston and Los Angeles areas. The principal provider enrollment task will be the revalidation of all HHAs in said areas.

Independent Organ Procurement Organizations – An Organ Procurement Organization performs or coordinates the retrieval, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

Religious Non-Medical Health Care Institutions – A RNHCI provides care to beneficiaries in need of skilled nursing facility care or hospital care when the beneficiary's religious beliefs preclude admission to one of these institutional providers. This does not mean that the beneficiary will receive hospital or SNF

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care in the RNHCI, but that the beneficiary elected to pursue a religious approach to healing. Since the use of diagnoses or medical oversight is prohibited in a RNHCI, they are not candidates for any CMS existing PPS and continue to be paid using the TEFRA methodology.

Histocompatibility Lab - Histocompatibility Laboratories provide services related to tissue typing testing for possible organ recipients and donors to determine compatibility for an organ transplant. They operate on a cost reimbursement basis and bill transplant centers for their services.

E. The Geographic-Assignment Rule

Providers that are not within one of the categories described above (HH&H, DME, RRB, or specialty & demos) will be assigned to the MAC that covers the state where the provider is located. There are two exceptions.

First a qualified chain provider (QCP) may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC that covers the state where the QCP's home office is located. The regulation at 42 CFR 421.404(b)(2) defines a qualified chain provider (QCP) as:

- Ten or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control, collectively totaling 500 or more certified Medicare beds; or
- Five or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control in three or more contiguous states, collectively totaling 300 or more certified Medicare beds.

CMS may assign non-QCP providers, as well as End Stage Renal Disease (ESRD) providers to an A/B MAC outside of the prevailing geographic assignment rule only to support the implementation of the MACs or to serve some other compelling interest of the Medicare program.

The second exception is for providers that meet the “provider-based” criteria of 42 CFR 413.65. Provider-based entities (other than HH+H providers) will be assigned to the MAC that covers the state where the main (“parent”) provider is assigned.

IV. Where will providers be assigned in the interim?

All existing providers with a Medicare claims history will remain in their current FI assignments until their workload is transferred to an A/B MAC. The “change of intermediary” process ended for individual providers in 2005, and ended for chain providers in 2007. A change of ownership now serves only to update CMS provider data with information about the new owner.

The workload currently serviced by a legacy FI will be absorbed by the incoming MAC within the 12 months following the award of MAC contract. In some situations the workload transition may be delayed by an award protest.

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New providers enrolling with Medicare will be assigned to the FI or MAC that covers the state where the provider is physically located, with a few exceptions:

- The “Multi-Provider Complex/Sub-Unit” relationship (ref: 42 CFR 483.5(b)). - An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the “geographic assignment rule.”
- An “initial enrollment” connected with a QCP. - If a QCP acquires a new hospital, skilled nursing facility, or critical access hospital that is located outside home office A/B MAC jurisdiction, then CMS will endeavor to assign the provider to the MAC that covers the state where the QCP’s home office is located. This special assignment is available only for “initial enrollments” – providers that are joining the Medicare program with neither an existing administrative contractor assignment nor a Medicare claims history.

The other exceptions track the MAC-world assignment rules discussed in Sections III-A through III-D above.

V. How long will my interim assignment last?

An “out-of-jurisdiction provider” (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with Sections III-A through III-D above (including the geographic assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after two events have taken place. The first event is when all 15 A/B MACs have been awarded and implemented. The second event is when all the systems and contractors that support the claims processing, provider enrollment, and cost report auditing functions at the departure and destination MACs are capable of supporting the move.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5979) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R333OTN.pdf>. To view any of the federal regulations cited in this article or in CR 5979, visit <http://www.gpoaccess.gov/cfr/index.html>.

If you have questions, please contact our office at 1-866-332-7025.

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July Quarterly Update to 2008 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in Skilled Nursing Facilities.

Provider Action Needed

This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS). CR 6009 adds HCPCS code J9303 (Injection, Panitumumab, 10MG) to the Major Category III. A. Chemotherapy services FI/A/B MAC Exclusion List retroactive to January 1, 2008.

Background

The Social Security Act (Section 1888) codifies the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB). The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are not subject to the consolidated billing provision of the SNF PPS. Services not appearing on this list submitted on claims to FIs/A/B MACs and carriers/A/B MACs, including DME MACs, will not be paid by Medicare to providers, other than a SNF, when included in SNF Consolidated Billing (CB).

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems will edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR 6009 adds HCPCS code J9303 to the Major Category III. A. Chemotherapy services FI/A/B MAC Exclusion List retroactive to January 1, 2008.

Medicare contractors will reopen and reprocess claims affected by this instruction when providers bring such claims to their contractor's attention.

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Additional Information

The official instruction, CR 6009, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1501CP.pdf>.

If you have any questions, please contact our office at 1-866-332-7025.

Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Medicare Part B Small Provider Forums: Point Pleasant, West Virginia

Palmetto GBA is sponsoring a General Medicare Part B Seminar in Point Pleasant, West Virginia on June 17th 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 by a question and answer session. All specialties are welcome!

| Date | Location | Time |
|------------------------|--|---|
| Tuesday, June 17, 2008 | Mason County Library 508 Viand Street Point Pleasant, WV 25550 | Medicare Updates (1:00 p.m. – 4:00 p.m.) |

How to Register

Registration is easy! To register through the Internet, follow these steps:

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

You will need to log in with your username and password to register. In order to register for a seminar, you must first create a username and password. For additional questions regarding registration, please call 1-866-332-7025.

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.

Please review your schedule and sign up today!

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Registration Form for 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:

_____ June 17, 2008, Point Pleasant, West Virginia

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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Initial Care Services & Observation or Inpatient Care Services: Tool Sheet

Change Request (CR) 5793 alerts providers to updates regarding: Payment for Initial Hospital Care Services (CPT codes 99221 - 99223) and Observation or Inpatient Care Services (Including Admission and Discharge Services) (CPT codes 99234 - 99236). It advises physicians and NPPs of the correct CPT codes to use when inpatient hospital care is less than 8 hours on the same calendar date, when a patient is admitted and discharged on a different calendar date, and when admitted for 8 hours but less than 24 hours on the same calendar date; and identifies medical record documentation requirements.

Palmetto GBA has developed a tool sheet to assist providers in determining the appropriate service to submit for payment. The tool sheet is divided into Day One and Day Two and beyond. It aligns the service provided with the appropriate CPT code to submit for payment.

| Day One | CPT Code(s) |
|---|--|
| Admitted less than 8 hours – discharged same calendar date | Initial hospital care: CPT codes 99221-99223 (Do not report CPT 99238 or 99239) |
| Admitted 8 hours but less than 24 hours – discharged same calendar date | Inpatient Care (includes admission & discharge): CPT codes 99234-99236 (Do not report CPT codes 99238 or 99239) |
| Admitted 24 hours: first calendar day | Initial Hospital Care: CPT codes 99221-99223 |
| Day Two and Beyond | CPT Code(s) |
| Discharged on second calendar date and beyond | Hospital Discharge Service: CPT code 99238 or 99239 |
| Remains in hospital on second calendar date and beyond | Subsequent Hospital Care: CPT codes 99231-99233 |

The billing physician shall:

- Meet the evaluation and management (E/M) documentation requirements for the billed CPT code.
- Identify that he/she was physically present and personally performed the initial hospital care services.
- Personally document the admission and discharge notes and include the number of hours the patient remained in inpatient care status.

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Resources:

- Medicare Claims Processing Manual (IOM 100-04), Chapter 12, Section 30.6.9.1
- Change Request 5793 located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1465CP.pdf>
- MLN Matters Article 5793 located on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles>

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Hospital Observation Services & Observation or Inpatient Care Services (Including Admission and Discharge Services): Tool Sheet

Change Request (CR) 5791 alerts providers to updates regarding: Payment for Hospital Observation Services (Current Procedural Terminology (CPT) Codes 99217 - 99220); and Observation or Inpatient Care Services (Including Admission and Discharge Services – CPT Codes 99234 - 99236).

It advises physicians and NPPs of the correct CPT codes to use when observation care is less than 8 hours on the same calendar date, when a patient is admitted to observation and discharged on a different calendar date, and when admitted to observation for 8 hours but less than 24 hours on the same calendar date. It also identifies medical record documentation requirements.

Palmetto GBA has developed a tool sheet to assist providers in determining the appropriate service to submit for payment. The tool sheet is divided into Day One and Day Two and beyond. It aligns the service provided with the appropriate CPT code to submit for payment.

| Day One* | CPT Code(s) |
|--|---|
| Admitted less than 8 hours (discharged same calendar date) | Initial Observation Care: CPT codes 99218-99220 (Do not report CPT code 99217) |
| Admitted 8 hours but less than 24 hours (Discharged same calendar date) | Initial Observation Care: CPT codes 99234 - 99236 (Do not report CPT code 99217) |
| Admitted 24 hours (First calendar date) | Initial Observation Care: CPT codes 99218 - 99220 |
| Day Two and Beyond * | CPT Code(s) |
| Discharged on second calendar date and beyond | Observation: CPT code 99217 |
| Remains in observation on second calendar Date and beyond | Established Patient Office/Outpatient CPT codes 99211-99215 |

*** When a patient is admitted to the hospital from observation status on the same date, the physician should only report the initial hospital care code.**

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The Medical Record shall include:

- Meet the evaluation and management (E/M) documentation requirements for the billed CPT code.
- Identify that he/she was physically present and personally performed the observation care services.
- Personally document the admission and discharge notes and include the number of hours the patient remained in observation care status

Resources:

- Medicare Claims Processing Manual (IOM 100-04), Chapter 12, Section 30.6.8
- Change Request 5791 located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1466CP.pdf>
- MLN Matters Article # 5791 located on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles>

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Inpatient Hospital Visits: Payment for General Codes

Provider Types Affected

Physicians and non physician practitioners (NPPs), submitting claims to Medicare Administrative Contractors (A/B MACs) and/or carriers for services provided to Medicare beneficiaries during a hospital visit.

Provider Action Needed

Providers should note the payment policy for billing inpatient hospital visits provided on the same day as critical care services. See the Key Points section of this article for a complete list of the updates.

Background

CR 5792 updates Chapter 12, Section 30.6.9 of the Medicare Claims Processing Manual. The updated section of this manual is attached to CR 5792 and the address/link to that CR is listed in the Additional Information section of this article.

Key Points

Physicians and qualified NPPs should note the payment policy requirements according to CR 5792 are as follows:

- When a hospital inpatient (or emergency department or office/outpatient) evaluation and management (E/M) service is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) and the previous E/M service may be paid for the same date of service.
- During critical care management of a patient those services that do not meet the level of critical care should be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a CPT code in the 99231-99233 range.
- Physicians and qualified NPPs may report both critical care services and an inpatient hospital care service for the same patient on the same calendar date when during critical care management of a patient the services do not meet the level of critical care services.
- Physicians and qualified NPPs are reminded that both Initial Hospital Care codes (CPT codes 99221-99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.
- Physicians and qualified NPPs are advised to retain documentation for discretionary Medicare carrier or A/B MAC review in case claims are questioned. The retained documentation must support why the same physician or physicians of the same specialty in a group practice submitted claims for both critical care services and other E/M services for the patient on the same date of service.

Additional Information

You may see the official instruction (CR 5792) issued to your Medicare A/B MAC or carrier by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1473CP.pdf>.

If you have questions, please contact our office at 1-866-332-7025.

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Blood-Derived Products for Chronic, Non-Healing Wounds

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6043 which provides the Centers for Medicare & Medicaid Services (CMS) updated policy regarding autologous blood-derived products for chronic, non-healing wounds.

CAUTION – What You Need to Know

Effective March 19, 2008, CMS is maintaining its current non-coverage determination for autologous platelet rich plasma (PRP) for the treatment of chronic, non-healing cutaneous wounds, and issuing a non-coverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds.

GO – What You Need to Do

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

Background

In 1992, the Centers for Medicare & Medicaid Services (CMS) issued a national non-coverage determination for autologous, platelet-derived wound healing formulas intended to treat patients with chronic, non-healing wounds. In December 2003, CMS issued a national non-coverage determination for use of autologous platelet rich plasma (PRP) for the treatment of chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in the Medicare National Coverage Determinations (NCD) Manual (Section 310.1; see http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4TXT.pdf.)

In April 2005, CMS issued an NCD to correct the erroneous potential for local coverage of becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, stating that, because it is usually self-administered, it would remain nationally non-covered under Part B based on the Social Security Act (Section 1861(s)(2)(A) and (B); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm.)

On March 19, 2008, CMS issued a Decision Memorandum following a National Coverage Analysis to evaluate the use of autologous blood-derived products for the treatment of chronic, non-healing cutaneous wounds, specifically the use of autologous PRP for the treatment of acute wounds where PRP is applied directly to the closed incision site, or for dehiscent wounds.

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CMS determined that the evidence is inadequate to conclude that autologous PRP for the treatment of chronic non-healing cutaneous wounds, acute surgical wounds when the autologous PRP is applied directly to the closed incision, or dehiscent wounds, improves health outcomes in the Medicare population.

Therefore, effective March 19, 2008, CMS is maintaining its current non-coverage determination for autologous PRP for the treatment of chronic, non-healing cutaneous wounds, and issuing a non-coverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds. Effective for claims with dates of service on or after March 19, 2008, the use of autologous PRP for the treatment of acute surgical wounds where the PRP is applied directly to the closed incision, or dehiscent wounds, will be denied by Medicare contractors.

Additional Information

The official instruction, CR 6043, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R83NCD.pdf>.

If you have any questions, please contact our office at 1-866-322-7025.

New Chapter in Medicare Claims Processing Manual for Independent Diagnostic Testing Facilities (IDTF)

Provider Types Affected

Independent Diagnostic Testing Facilities (IDTFs) submitting claims to Medicare Administrative Contractors (A/B MACs) fiscal intermediaries (FIs) or carriers for services provided to Medicare beneficiaries.

Impact on Providers

Change Request (CR) 5815 alerts providers to the fact that information from the Medicare Program Integrity Manual, Chapter 10, regarding claims processing instructions for IDTFs is being excerpted and added to Medicare Claims Processing Manual via Chapter 35—a new chapter in the Medicare Claims Processing Manual. Currently, the Medicare Claims Processing Manual does not have claims processing instructions for IDTFs and this CR notifies providers of the availability of this information in that manual. No changes in policy are conveyed in CR 5815.

Key Points of CR 5815

Providers note that information regarding IDTF claims processing has been excerpted from the Medicare Program Integrity Manual, chapter 10, and moved to the Medicare Claims Processing Manual, chapter 35, which is a new chapter. The new chapter 35 is available as an attachment to the official instruction of CR 5815. The new chapter contains information on the following:

- General coverage and payment policies applicable to IDTFs;
- Medicare's definition of an IDTF;
- Claims processing instructions with emphasis on:
 - Billing issues;
 - Transtelephonic and electronic monitoring services; and
 - Slide preparation facilities and radiation therapy centers.
- Ordering of tests;
- Purchased diagnostic tests;
- Interpretations of tests performed off the premises of the IDTF; and
- Restrictions that do not allow billing for strictly therapeutic procedures.

IDTFs are reminded that the National Provider Identifier (NPI) of the ordering physician must be supplied in box 17B of the CMS-1500 form and in the appropriate loop of the ANSI X12 837P electronic claim format, effective for services on or after May 23, 2008.

Additional Information

To see the official instruction (CR 5815) issued to your Medicare Carrier, FI, or A/B MAC go to <http://www.cms.hhs.gov/Transmittals/downloads/R1504CP.pdf>. As already mentioned, the new Chapter 35 of the Medicare Claims Processing Manual is attached to CR 5815.

If you have questions, please contact our office at 1-866-322-7025.

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Incident to Policy Update

Provider Types Affected

Physicians, nonphysician practitioners (NPP), and other providers who bill Medicare carriers and A/B MACs for services provided to Medicare beneficiaries

What You Need to Know

CR 5288, from which this article is taken, clarifies current Medicare policy regarding services provided as incident to the services of physicians or nonphysician practitioners (NPP) in the office. Specifically, it updates information in the Medicare Benefit Policy Manual (Chapter 15 -- Covered Medical and Other Health Services, Sections:

- 50.3 - Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered;
- 60 - Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service;
- 60.1 - Incident To Physician's/NPP's Professional Services in Office or Physician/NPP Owned and Operated Clinic;
- 60.2 - Services of Nonphysician Personnel Furnished Incident To Physician's Services; and
- 60.3 - Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics)

For policies relative to hospital outpatient services see the Medicare Benefit Policy Manual, Chapter 6, Section 20.5.

CR 5288 represents no significant change in Medicare policy. It is intended only to clarify current policy and, where local interpretations may differ, to add consistency.

Background

The number of services provided as incident to the services of physicians/NPPs has grown continuously. As the benefit is applied in various settings for different services, the original instructions appeared insufficient. Therefore, in CR 5288, from which this article is taken, the Centers for Medicare & Medicaid Services (CMS) is responding to continued requests for clarification of policies related to Part B services provided incident to the services of physicians.

Key Points

The update of the Medicare Benefit Policy Manual is extensive and will not be repeated in this article. To view the manual update itself, see CR 5288 at <http://www.cms.hhs.gov/Transmittals/downloads/R87BP.pdf>. In this article, we will only emphasize the following key points of CR 5288:

- Carriers and A/B MACs will interpret a service as integral to the initial service when it is both essential to, and connected to, that service.
- When carriers and A/B MACs are aware that a service is furnished by staff other than the physician/NPP who is overseeing the patient's care, they will not pay for services incident to a physician's/NPP's service unless the services meet the requirements in Medicare Benefit Policy Manual, Chapter 15

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(Covered Medical and Other Health Services, Section 60 (Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service)) and its subsections.

- When carriers and A/B MACs are aware that a service is furnished by staff other than the physician/NPP overseeing the patient's care, carriers and A/B MACs will not pay for services incident to a physician's/NPP's service unless there is documentation authorizing the incident to service.
- Carriers and A/B MACs will not pay for services incident to the services of a physician/NPP if the services are for a new problem.
- Carriers and A/B MACs will use clinical judgment in determining whether the record contains sufficient documentation to indicate that a physician/NPP is overseeing the provision of services appropriately for the patient's condition, and whether the person furnishing the incident to service is appropriately qualified.
- Carriers and A/B MACs will apply the policies for services incident to a physician's/NPP's services in the office only in the identifiable boundary of an office or in a single room.
- Where services are provided in a home or in a skilled nursing facility (SNF), outside the boundary of an office suite, carriers and A/B MACs will require that the supervisor be in the same room as the patient and the staff furnishing a service, providing the equivalent of personal supervision.
- For payment purposes, carriers and A/B MACs will require:
 - That documentation in the medical record conform to the policy in CR 5288;
 - An authorization for services provided incident to the physician/NPP initial service; and
 - That the name and professional identities of the people who furnished the services must be in the medical record.
- The authorization may be an "order" which may be part of the care plan. The authorization does not have to be in any specific form (it may be an order or part of a plan, treatment note, or team meeting note), but should indicate the physician's intent that further services will be provided. It is appropriate that the physician may plan to provide a follow-up service personally and later assign the service to qualified staff. It is not necessary that a formal order be written to the staff, but services may not be billed if staff has not been authorized to provide them and that authorization must be present in the medical record.
- The authorization will not be on the claim and therefore, will be identified only when the record is reviewed.
- Services unrelated and not essential to the initial service will not be paid as incident to the initial, covered service. These services may represent new problems for which an initial physician/NPP service is required.
- Carriers and A/B MACs are not required to perform medical review on all claims to determine whether there is a new problem, but if medical review reveals that there is a new problem, they will not pay for that service incident to the physician's service without a prior physician's service.
- Staff may be overqualified to provide a service, but the service will not be allowed as incident to if the service should have been provided under another benefit such as a physician's service or services of another professional. Carriers and A/B MACs will take special care in determining whether services provided by a physician or other professional incident to the services of a physician are actually incidental services or they should be billed, e.g., as physician services by enrolled physicians, or as diagnostic tests.

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- CMS requires that the professional title of the person who provides the service be written in the medical record in order that carriers and A/B MACs will know the staffs' professional qualifications or licensure.

Additional Information

You can find more information in the official instruction, CR 5288, located at <http://www.cms.hhs.gov/Transmittals/downloads/R87BP.pdf>.

You will find the updated Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), Sections 50.3 (Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered), 60 (Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service), 60.1 (Incident To Physician's/NPP's Professional Services in Office or Physician/NPP Owned and Operated Clinic), 60.2 (Services of Nonphysician Personnel Furnished Incident To Physician's Services), and 60.3 (Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics) as an attachment to that CR.

All other manuals referenced in CR 5288 are available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

If you have any questions, please contact our office at 1-866-332-7025.

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Ambulance Fee Schedule: Conversion Factor File for CY 2009 Ambulance Inflation Factor

Note: This article was revised on May 6, 2008, to correct the implementation date of the instruction. That date is October 6, 2008. All other information remains the same.

Provider Types Affected

Ambulance providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ambulance services provided to Medicare beneficiaries

What Providers Need to Know

This article is based on Change Request (CR) 6000, which revises the ambulance fee schedule file layout for Calendar Year (CY) 2009. Specifically, only the conversion factor field is being modified to:

- Remove the sign in the numeric field; and
- Expand the length of the Conversion Factor field.

For claims with dates of service on or after January 1, 2009, Medicare contractor(s) will recognize the new Ambulance Fee Schedule file layout. For claims with dates of service prior to January 1, 2009, Medicare contractors will recognize the current layout.

Additional Information

The official instruction, CR 6000, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1499CP.pdf>.

The ambulance fee schedule public use files are available at http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp.

If you have any questions, please contact our office at 1-866-332-7025.

Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

Provider Types Affected

Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC) and Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for administering or supplying Erythropoiesis Stimulating Agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

What You Need to Know

Following a National Coverage Analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a Decision Memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

CR 5818 communicates the NCA findings and the coverage policy in the National Coverage Determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007; do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementations of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

Background

Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

Reasonable and Necessary ESA Use

CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

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- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.);
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the, 150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alfa;
- Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is = 1g/dL (hematocrit = 3%);
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment;
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2 week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose; and
- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use

Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis;
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81);
- Anemia of cancer not related to cancer treatment;
- Any anemia associated only with radiotherapy;
- Prophylactic use to prevent chemotherapy-induced anemia;
- Prophylactic use to reduce tumor hypoxia;
- Erythropoietin-type resistance due to neutralizing antibodies; and
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

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Claims Processing

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for HCPCS codes J0881 or J0885 when:

- Billed with HCPCS modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with HCPCS modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with HCPCS modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with HCPCS modifier EB (ESA, anemia, radio-induced).

Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an Advance Beneficiary Notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare Summary Notice 15.20, the following policies [NCD 110.21] were used when we made this decision, and remittance reason code 50, these are non-covered services because this is not deemed a 'medical necessity' by the payer.

However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21

Medicare contractors will not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

Additional Information

This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council,

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and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (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 Social Security Act.)

The official instruction, CR 5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf>. The second transmittal revises the Medicare Claims Processing Manual and it is at <http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf>.

If you have any questions, please contact our office at 1-866-332-7025.

Therapy Personnel Qualifications and Policies Effective January 1, 2008

Provider Types Affected

Physicians, non physician practitioners, and other providers who bill Medicare carriers, fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MAC) for outpatient therapy services provided to Medicare Beneficiaries.

What Providers Need to Know

CR 5921, from which this article is taken, provides guidance for new regulations (See the Federal Register of November 27, 2007, for the discussion in the Medicare Physician Fee Schedule (MPFS) final rule of 2008.) that address outpatient therapy services, including personnel qualifications and the timing of recertification of plans of care for Part B services. This article summarizes these regulations.

Background

Professional standards have changed since the qualifications for individuals providing outpatient therapy services (physical therapy, occupational therapy and speech-language pathology services in 42CFR484.4 was last modified. In the calendar year 2008 Medicare Physician Fee Schedule Final Rule with comments, the Centers for Medicare & Medicaid Services (CMS) updated them to address more modern requirements. CR 5921, from which this article is taken, provides guidance for these new regulations.

Effective January 1, 2008, these personnel requirements are being applied to all settings except inpatient hospital, including critical access hospital services, and post hospital SNF care.

Effective July 1, 2008, these personnel qualifications are being applied consistently in all Medicare settings where therapy services are furnished.

Certain other policies concerning therapy services and policies concerning recertification of plans of care for Part B services, some of which differ by setting are also effective January 1, 2008.

Note: The regulations in 42CFR409.17 concerning inpatient hospital services and inpatient critical access hospital services, and those in 42CFR409.23 concerning post hospital skill nursing facility (SNF) care will become effective July 1, 2008. Only the personnel qualifications for those settings are addressed in this CR.

Qualifications for Individuals Providing Outpatient Therapy Services

Practice of Physical Therapy

For Medicare program coverage purposes, the new personnel qualifications for physical therapists were discussed in the 2008 Medicare Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January

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15, 2008. To view the official qualifications for physical therapists, see the revised Chapter 15, Section 230.1, of the Medicare Benefit Policy Manual, which is attached to CR 5921 at <http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf>.

Practice of Occupational Therapy

The new personnel qualifications for occupational therapists (OT) were also discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008. The official personnel qualifications of OTs are in the revised Chapter 15, Section 230.2 of the Medicare Benefit Policy Manual attached to CR 5921.

Practice of Speech-Language Pathology

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.

Timing of Recertification of Plans for Care for Part B services

CR 5921 also addresses the timing of recertification of plans for care for Part B services. The following summarizes the changes articulated in the Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), Section 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care).

First, please note that the physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements for the duration of the episode of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

The timing of plan recertification changed on January 1, 2008. Therefore, those certifications that were signed on, or prior to December 31, 2007, follow the rule in effect at that time; which required recertification every 30 calendar days. However, certifications that are signed on, or after January 1, 2008, follow the new rules in CR 5921 and are effective for an appropriate episode length based on individual patient condition up to 90 calendar days from the initial therapy treatment.

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Specifically, a physician/NPP may certify or recertify a plan for whatever duration of treatment episode they determine is appropriate, up to a maximum of 90 calendar days. A certification interval will be the same length as an episode, if the episode is less than 90 calendar days. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification, it is appropriate (although not required) that the clinician who develops the plan estimate the duration of the entire episode for that setting.

Note: The Progress Report Period has not changed. Progress reports are due at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period.

Other issues discussed in CR 5921 include:

- Medicare contractors will require that a new or significantly modified (changed) plan of care for outpatient therapy services be certified no more than 30 calendar days after the initial therapy treatment under that plan. Rules for delayed certification have not changed.
- Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certifies and/or recertifies the plans.
- Medicare contractors will require recertification of outpatient therapy plans of care in intervals not to exceed 90 calendar days after the initial treatment day.
- Physicians/NPPs who feel that a visit for an examination is necessary prior to certifying the plan, or during the episode of treatment should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care that is certified. If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan.
- Policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of a physician's care may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.
- The guidance for delayed certification has not changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long term goals. It is expected that modifications to the plan concerning short term goals or treatment techniques will be made frequently and these changes do not require certification or recertification.
- Medicare contractors will not require a certification "statement" at the time of certification.
- Medicare contractors will require a clinicians or facilities that appropriately furnish aquatic therapy in a community pool to rent or lease at least a portion of the community pool for the exclusive use of the therapist's patients.

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- The same policies, e.g., concerning safety and medical necessity, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool.

Additional Information

You can find more information about the new therapy personnel qualification requirements and the timing of recertification of plans of care (effective January 1, 2008) by going to CR 5921, located at <http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf>. The updated Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), Sections 220 (Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance), 220.1.2 (Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services), 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care), 220.3 (Documentation Requirements for Therapy Services), 230.1 (Practice of Physical Therapy), 230.2 (Practice of Occupational Therapy), 230.3 (Practice of Speech-Language Pathology), 230.4 (Services Furnished by a Physical or Occupational Therapist in Private Practice) can be found as an attachment to that CR.

If you have any questions, please contact our office at 1-866-332-7025.

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

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

Within each policy, we include all applicable CPT procedure codes and ICD-9 diagnosis codes. We will publish or reference a revised policy when Medicare coverage is revised. However, *we do not publish revised medical policies solely to update a CPT procedure or ICD-9 diagnosis code that has been revised or deleted*. If a CPT or ICD-9 code is deleted and replaced with a new code, the medical policy in effect will apply to the new code. Our claims processing system will be updated with these coding changes as necessary. If you have any questions concerning a coding change, please contact the Medicare Part B Provider Call Center at 1-866-332-7025.

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

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

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

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Local Coverage Determination Updates

| LCD | Change | Effective Date |
|---|--|----------------|
| Chemotherapy and Biologicals 2002-29LR41 | Revision Made: Addition of ICD-9 codes 141.0-149.9 as supporting medical necessity for HCPCS codes J9070-J9097 (Cyclophosphamide). | 06/01/2008 |

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

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



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

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

General Information

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

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

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

Date of initial determination: _____ Provider Phone Number: _____

*Date of Service: _____ Who are you:

*CPT code(s): _____ Provider

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

Billed Charge: _____ Patient with Medicare

Patient's Representative

Other

This is an appeal for:

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

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

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

Reason for request: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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

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Reconsideration Request Form - QIC North (Ohio)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. At a minimum, **you must complete/include information for items 1, 2a, 6, 7, 11, & 12** but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

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

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

Contractor Number: 00883

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

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Reconsideration Request Form - QIC South (West Virginia)

Directions: If you wish to appeal a redetermination decision, please fill out the required information below and mail this form to the address shown below. At a minimum, **you must complete/include information for items 1, 2a, 6, 7, 11 & 12** but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

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

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

Contractor Number: 00884

Palmetto GBA – West Virginia Medicare Part B Carrier
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 567-9232
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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 Contact Center

1-866-332-7025 CSR (Toll-Free)

1-877-567-9232 IVR (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 Beneficiary Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

<http://www.PalmettoGBA.com>

Important Sources For You

- <http://www.cms.hhs.gov>
- <http://www.cms.hhs.gov/MLNGenInfo>
- <http://www.cms.hhs.gov/CMSforms/CMSforms/list.asp>
- <http://www.cms.hhs.gov/QuarterlyProviderUpdates>
- <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

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

Attention: Billing Manager

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