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Medicare advisory

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2007, Issue 3 *www.cms.hhs.gov* *www.PalmettoGBA.com* *March 2007*

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You Are Responsible. . .

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

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

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History & Physical Information: Clarification from CMS

Question: Can the Physician Assistant (PA), Medical Assistant (MA), or Registered Nurse (RN) document the HPI and the physician/NPP refer to what the PA, MA, or RN documented? For example, "agree with above note."

Answer: Recently, Palmetto GBA received clarification from CMS on the answer to this question. Per the 1995 and 1997 E/M documentation guidelines the ONLY portion of the history that may be PERFORMED by ancillary staff of the physician (e.g., employed RN, LPN, CNA etc.) are the Review of Systems and Past/Family/Social History and it MUST be reviewed by the physician or NPP who MUST write a statement that it is reviewed and correct or add to it.

Only the physician or NPP who is conducting the E/M visit can PERFORM the History of Present Illness (HPI). This is physician work and not relegated to ancillary staff. The exam and medical decision making are also physician work and not relegated to ancillary staff.

If ancillary staff are present he/she could document what is dictated and performed by the physician or NPP in the HPI but the ancillary staff CANNOT PERFORM the HPI.

It is very important to convey whether you are addressing documenting or performing.

Resources:

- CMS 1995 & 1997 E/M Guidelines - http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp
- Palmetto GBA Web site - http://www.PalmettoGBA.com/boh/Guide (Ohio) or http://www.PalmettoGBA.com/bwv/Guide (West Virginia), and select Evaluation and Management Guidelines, Documentation & Coding Tips.

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Hospice Enrolled Patients: Annual Coding & Coverage Reminders

Modifier Requirements

For services provided to beneficiaries enrolled in hospice, **ALL** providers must submit HCPCS modifier GV or GW. Services submitted without one of the following HCPCS modifiers will be denied.

HCPCS Modifier	Descriptor
GV	Attending physician not employed or paid under agreement by the patient's hospice provider. *(Note: In this instance, the attending physician designation also applies to nurse practitioners.)*
GW	Service not related to the hospice patient's terminal condition.

Hospice Overview

Medicare beneficiaries entitled to hospital insurance (**Part A**) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his/her election period. Election/termination dates are retained on the Common Working File (CWF).

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG). Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. It should be noted that predicting life expectancy is not always exact.

When hospice coverage is elected, the beneficiary waives all rights to Medicare **Part B** payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, *except for professional services of an attending physician, which may include a nurse practitioner.*

Attending Physician

Even though a beneficiary elects hospice coverage, he/she may designate and use an attending physician, who is not employed by nor receives compensation from the hospice for professional services furnished,

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in addition to the services of hospice-employed physicians. The professional services of an attending physician, which are reasonable and necessary for the treatment and management of a hospice patient's terminal illness, are not considered hospice services.

If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under **Part B**. These physician professional services are submitted to Medicare **Part A** by the hospice.

Services provided by an independent attending physician, who may be a nurse practitioner, must be coordinated with any direct care services provided by hospice physicians.

Only the direct professional services of an independent attending physician, who may be a nurse practitioner, may be submitted; the costs for services such as lab or x-rays are not to be included on the claim. When the attending physician or nurse practitioner furnishes a terminal illness related service that includes both a professional and technical component (e.g., x-rays), he/she submits the professional component of such services to the carrier and looks to the hospice for payment for the technical component. Likewise, he/she would look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests).

Payments for the services of the attending physician are not counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care.

Substituting Physician

If another physician covers for a hospice patient's designated attending physician, the services of the substituting physician are submitted by the designated attending physician under the reciprocal or locum tenens instructions. In such instances, the attending physician submits using HCPCS modifier GV in conjunction with HCPCS modifier Q5 or Q6.

Services Under Payment Arrangement with the Hospice

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician, who may be a nurse practitioner, the physician must look to the hospice for payment. In this situation the physician's services are hospice services and are submitted by the hospice to its fiscal intermediary.

Services by Individuals other than the Designated Attending Physician or Nurse Practitioner

Services related to the terminal illness, furnished by individuals or entities other than the designated attending physician (or nurse practitioner), are included in the hospice rate and paid through the fiscal intermediary. Such services include DME, supplies, or independently practicing speech or physical therapist services related to the terminal illness.

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Hospice Pre-Election Evaluation and Counseling Services

HCPCS code G0337 "Hospice Pre-Election Evaluation and Counseling Services", effective for dates of service on and after January 1, 2005, is only payable when submitted by a hospice to its Regional Home Health Intermediary (RHHI). If a "new patient" physician evaluation and management service (CPT codes 99201-99205) is submitted for the same date of service, same physician, as HCPCS code G0337, it will be denied.

Refer to the Medicare Claims Processing Manual (Pub 100-4), Chapter 11, Section 10.1 for more information. Go to http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf.

Care Plan Oversight

The attending physician may submit care plan oversight services for a hospice enrollee. Refer to the Medicare Claims Processing Manual (Pub 100-4), Chapter 11, Section 40.1.3.1 for more information. Go to http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf

Managed Care Enrollees who Elect Hospice

Federal regulations require that Medicare fee-for-service contractors (carriers) maintain payment responsibility for managed care enrollees who elect hospice. Refer to the Medicare Claims Processing Manual (Pub 100-4), Chapter 11, Section 40.2.2 for more information regarding Medicare+Choice claims. Go to http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf.

Services Unrelated to the Terminal Illness

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be submitted by the rendering provider for non-hospice payment. These services are coded with HCPCS modifier GW "Service not related to the patient's terminal condition". If warranted, contractors may conduct prepayment development or post payment review to validate that services submitted with HCPCS modifier GW are not related to the patient's terminal condition.

Hospice Notice of Admission

The Notice of Admission (NOA), sometimes referred to as the Notice of Election (NOE), is not required or reviewed for payment, and should not be submitted with the claim. (UB92 Forms)

Additional Hospice Information

The content of this article and additional hospice information is available at the following CMS (Centers for Medicare and Medicaid Services) Web sites:

http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf

http://www.cms.hhs.gov/providers/hospiceps/

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Processing All Diagnosis Codes Reported on Claims

Provider Action Needed

This article is derived from CR 5441, which announces the requirement that (effective for claims processed July 1, 2007, and later) the Part B standard systems and the carrier claims processing systems capture and process up to eight diagnosis codes on all of your claims (both paper and electronic). You should make sure that your billing staffs are aware of these changes that allow all eight diagnosis codes on Medicare claims effective, July 1, 2007.

Background

While the ANSI 837P 4010A allows a maximum of eight diagnosis codes to be reported for each claim, the Medicare Part B standard systems and the carrier claims processing systems have historically used only the first four diagnosis codes reported on the claim when processing the HIPAA format claims. Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determinations.

The purpose of CR 5441 is to finalize the requirement that the Part B standard system and the carrier claims processing systems be modified to process your paper and electronic claims using all diagnosis codes that you report on the claim (up to eight).

Additional Information

You can find the official instruction, CR 5441 on the CMS Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1157CP.pdf.

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

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CMS Actions to Reverse Invalid Overpayments

Provider Action Needed

This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 – 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims; your Medicare contractor is in the process of correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, stay tuned for additional details on our Web site (Ohio providers: http://www.PalmettoGBA.com/boh) and/or (West Virginia providers: http://www.PalmettoGBA.com/bwv).

Background

In *MLN Matters* article SE 0681 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0681.pdf), the Centers for Medicare & Medicaid Services (CMS) advised providers of certain eligibility system issues related to managed care Medicare beneficiaries. In brief, article SE 0681 alerted providers that, in some instances, Medicare may be recovering certain overpayments due to system updates on beneficiary eligibility. When such overpayments are identified, Medicare systems generate a managed care informational unsolicited response (MCIUR), which triggers the overpayment recovery.

During the week of December 17, 2006, Medicare systems were updated with some incorrect Managed Care enrollment data, which, in turn, caused the systems to create some incorrect MCIURs. Medicare files have now been corrected and CMS is working diligently with Medicare contractors to stop the invalid overpayment recoveries from occurring. In addition, where action to recover the overpayments has already occurred, CMS has instructed your contractor to reverse the action and reissue payment to you.

Key Points

CR 5507 states that recovery action should stop if it has been initiated and reversed if MCIURs have already affected a recovery.

Physicians and other providers who bill Medicare contractors need not take any action since contractors will automatically make the necessary adjustments as CR 5507 is implemented.

Your contractor will post more detailed information on their Web site as CR 5507 is implemented.

Additional Information

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

For complete details regarding this issue, please see the official instruction (CR 5507) issued to your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R262OTN.pdf.

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CMS Quarterly Provider Update

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

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

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

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

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Timeliness Standards for Claims Processing (Other-Than-Clean Claims)

Provider Action Needed

This article is intended as informational only and is based on Change Request (CR) 5355, which provides requirements for all carriers and MACs for timeliness for processing "other-than-clean" claims.

Background

The Social Security Act (Section 1869(a) (2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) mandates that the Centers for Medicare & Medicaid Services (CMS) process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are classified as "other-than-clean" claims, and "other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

"Clean claim" means a claim that does not contain a defect requiring the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the timely filing period (see the Social Security Act 1842 (c) (2) (B); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm).

"Other Than Clean Claims" Any claim that does not meet the definition of clean claim above. These are complete claims that require manual intervention on the part of the contractor to be adjudicated.

CR 5355 instructs the Medicare contractor (carrier/MAC) to process all "other-than-clean" claims and notify the provider and beneficiary of the determination within 45 calendar days of receipt. See Medicare Claims Processing Manual (Publication 100-04, Chapter 1, Section 80.2.1; http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf) for the definition of "receipt date" and for timeliness standards for clean claims.

However, when the Medicare contractor develops the claim by asking the provider/supplier or beneficiary for additional information, the contractor will:

- Cease counting the 45 calendar days on the day that the contractor sends the development letter requesting the additional information, and
- Resume counting the 45 calendar days upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary.

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EXAMPLE:
The Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information.

Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to:
- Process the claim, and
- Notify the individual that filed the claim of the payment determination for that claim.

CR 5355 instructs Medicare contractors to follow existing procedures relative to both:
- The length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters, and
- Situations where the provider/supplier and/or beneficiary does not respond.

For dates of receipt on and after July 1, 2007, Medicare contractors are instructed to process all "other-than-clean" claims and notify the beneficiary and the provider filing the claim within 45 calendar days of receipt, except when the contractor requests additional information from the provider/supplier or beneficiary, or to another contractor (e.g., the Coordination of Benefits Contractor, another claims processing contractor)

Instructions in CR 5355 do not apply to the following types of claims:
- Claims where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC),
- Claims the contractors are required to hold due to CMS instructions,
- Claims rejected by the translator process,
- Claims where the Medicare contractor is unable to process due to technical issues with Medicare's beneficiary record or beneficiary identification issues, and
- Claims in development due to processing requirements (e.g., medical review), in Publication 100-08, the *Medicare Program Integrity Manual* (http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage).

Additional Information

For complete details, please see the official instruction issued to your carrier/MAC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1173CP.pdf on the CMS Web site.

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

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Medicare Patient Eligibility: Part C Plan Type Description Display on Common Working File (CWF)

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans.

A plan directory will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in Private Fee-for-Service (PFFS) plans. PFFS plans are very different from the more traditional MA HMO type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a Web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including the amount the provider is permitted to collect from the enrollee; and
- Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

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A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a Web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" Downloadable document on http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

To view the official instruction (CR 5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf.

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

Note: This article was revised on February 9, 2007, to clarify the language in the first bullet point under "Billing Guidelines" on page 2. All other information remains the same.

Key Points

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

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

Background

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

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

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

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

Billing Guidelines

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

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

Additional NPI-related information can be found at http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS Web site.

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

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

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

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

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

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

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Nine-Digit ZIP Codes: Determine the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) & Anesthesia Services

Please note: These changes do not affect providers in Ohio and West Virginia at this time.

Provider Action Needed

Impact to You

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1, if you do not include the full nine-digit ZIP code on your claims for services paid by Medicare carriers or MACs under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services, your claim will be treated as unprocessable.

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1, if a valid full nine-digit ZIP code is not present on the Provider Master File Address ZIP code, services paid by the FIs/MACs under the MPFS and for anesthesia services, your claim will be treated as unprocessable.

What You Need to Know

Effective October 1, 2007, for services rendered in the areas defined by the ZIP codes in Table 1, Medicare will require that you provide the nine-digit ZIP code for the location where services were rendered on your claims for services paid by carriers/MACs under the MPFS and for anesthesia services. CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.
Effective October 1, 2007, for services rendered in the areas defined by the nine-digit ZIP codes in Table 1, Medicare will require a valid nine-digit ZIP code on the Provider File Master Address for services paid by the FIs/MACs under the MPFS and for anesthesia services.

What You Need to Do

Make sure that your billing staffs are aware that if you provide services paid by carriers/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears in Table 1, below; effective for dates of service on or after October 1, 2007, they must include the nine-digit ZIP code in the claim.

Make sure that if you provide services paid by FIs/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears in Table 1, a valid nine-digit ZIP code is present on the Provider File Master Address. If a valid nine-digit ZIP code is not on the file, submit a CMS-855A, the Medicare Enrollment Application, with a valid nine-digit ZIP code.

Background

Reimbursement Based on the Location Where the Service Was Rendered

Where you actually provide services paid under the MPFS and anesthesia services determines the amount of your reimbursement. More specifically, Medicare reimburses you for these services based on the locality, which is determined from the ZIP code that is on the claim submitted to carriers/MACs. The ZIP code on

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the Provider File Master Address is used to determine the locality on the claims submitted to FIs/MACs. The ZIP codes that your Medicare contractors use to determine the payment locality come from the CMS ZIP code file, which conforms to the United States Postal Service convention of assigning ZIP codes into dominant counties.

CMS has become aware that some ZIP codes cover more than one payment locality; in some cases, while the service may actually be rendered in one county, because of the ZIP code it may be assigned into a different county. This causes a payment issue when each of the counties is associated with a different payment locality resulting in a different payment amount.

Nine-Digit ZIP Codes

CR5208, from which this article was taken, corrects this issue. Effective October 1, 2007, you will have to include the full nine-digit ZIP code for anesthesia services and for services paid under the MPFS by carriers/MACs when those services are provided in a ZIP code area that crosses payment localities (see Table 1, below). Note that services on the Purchased Diagnostic Abstract File are all payable under the MPFS, thus the 9-digit ZIP code requirement also applies to those services.

There are some important details that you should know:

Exceptions

There are two instances in which you do not need to submit the nine-digit ZIP code in claims for services payable under the MPFS and for anesthesia services:

- You may continue to submit claims with five-digit ZIP codes if you provide these services in ZIP code areas that do not cross payment localities (not listed in Table 1);
- There is no current requirement for the submission of a ZIP code when the place of service (POS) is "Home" or any other places of service that your Medicare contractor currently considers to be the same as "Home."

As necessary, CMS will provide quarterly updates of the list of the ZIP codes that cross localities.

You should submit your claims for ambulance and lab services using five-digit ZIP codes, as your carrier/MAC will continue to use the five-digit codes for determining payment.

Claims for ambulance services will continue to be priced using 5-digit ZIP codes by the FIs/MACs. Laboratory services will continue to be priced by the FIs/MACs using the locality for non-fee based services.

Master Address

FIs determine locality based upon the ZIP code of the provider's physical address, which, including the ZIP code is stored on the provider file as the master address.

Effective July 1, 2007, institutional providers, with a ZIP code displayed in Table 1, will need to submit a

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valid nine-digit ZIP code on the CMS 855-A when the Provider File Master Address ZIP code is 5-digits, the last 4-digits of a 9-digit ZIP code are zeroes, or the last 4-digits of a 9-digit ZIP code do not match a 4-digit extension on the ZIP code file.

Claims Returned as Unprocessable

To re-emphasize, if you provide only a 5-digit ZIP code on a claim for services payable under the MPFS and for anesthesia services that you provide in one of the ZIP code areas that crosses localities (requires a nine-digit ZIP code to be processed), your carrier/MAC will return this claim as unprocessable. Returned claims will have the following Remittance Advice and Remark Code messages:

Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remark Code MA114 – "Missing/incomplete information on where the services were furnished."

Effective for dates of service on or after October 1, 2007, if an invalid ZIP code is present on the Provider File Master Address for claims payable under the MPFS and for anesthesia services provided in one of the ZIP code areas that crosses localities, your FI/MAC will return the claim as unprocessable.

Table 1 - ZIP Codes that Cross Payment Localities by State

State	ZIP Code			
Arkansas (AR)	71749 71953	72338 72395	72444 72644	
Arizona (AZ)	85534			
California (CA)	90265 90623 90630 90631 90638 91304 91307 91311 91361	91362 91709 91766 91792 93013 93243 93252 93536 93560	94303 94514 94515 94550 94571 95023 95033 95076 95304	95377 95391 95476 95616 95690 95694 96056
Delaware (DE)	19952	19973		

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State	ZIP Code			
Florida (FL)	32948	33920	34141	34972
	33440	33955	34142	34974
	33917	33972		
Georgia (GA)	30011	30135	30223	30519
	30014	30143	30224	30534
	30019	30153	30228	30548
	30025	30178	30233	30559
	30040	30179	30234	30620
	30055	30180	30248	30641
	30056	30183	30268	30650
	30101	30184	30276	30663
	30102	30185	30506	30730
	30107	30187	30517	31029
	30120	30205	30518	
Idaho (ID)	83342	83856		
Illinois (IL)	60007	60407	60544	62280
	60010	60410	60554	62286
	60013	60416	60559	62355
	60015	60423	60935	62361
	60021	60431	60940	62366
	60042	60432	60950	62538
	60050	60439	62031	62546
	60051	60447	62044	62553
	60074	60449	62052	62557
	60081	60464	62053	62558
	60089	60466	62054	62630
	60090	60467	62075	62638
	60102	60468	62080	62643
	60103	60475	62081	62667
	60118	60477	62082	62690
	60120	60481	62083	62692
	60126	60504	62231	62801
	60133	60506	62237	62808
	60140	60511	62238	62831
	60142	60521	62253	62877
	60151	60523	62262	62882
	60172	60527	62263	62883
	60178	60538	62268	62907
	60401	60543	62272	62916

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State	ZIP Code			
Iowa (IA)	51630 51640	52542 52573	52626 52761	
Kansas (KS)	66012 66013 66018	66021 66025	66083 66102	66109 66112
Kentucky (KY)	40965	42079	42223	42602
Massachusetts (MA)	01432 01434	01930 02324	02339	02762
Maryland (MD)	20601 20607 20613 20714	20736 20754 20842	20871 21757 21771	21776 21787 21791
Michigan (MI)	48005 48041 48062 48118 48137 48160	48166 48169 48178 48189 48353 48371	48380 48428 48430 48438 48439 48442	48455 48462 49229 49236 49240 49285
Minnesota (MN)	56136 56144	56164 56219	56220 56257	56744
Missouri (MO)	63005 63015 63020 63023 63028 63030 63041 63060 63069	63071 63072 63087 63348 63357 63535 63548 63627 64024	64034 64048 64061 64062 64070 64075 64077 64080	64082 64147 64439 64444 64484 64492 64733 64784
Montana (MT)	59030	59847		
Nebraska (NE)	68719 68755	68777 69168	69212 69216	69352 69358
Nevada (NV)	89061			
New Hampshire (NH)	03579	03813		

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State	ZIP Code			
New Jersey (NJ)	07735 07747	08512 08525	08530 08540	08558 08560
New York (NY)	10505 10541 10579	11001 11040	11096 12167	12434 13750
North Dakota (ND)	58030 58041 58043	58053 58225 58413	58436 58439 58568	58623 58653
Oregon (OR)	97002 97014 97032 97056	97064 97071 97119 97123	97128 97132 97140	97231 97362 97375
Pennsylvania (PA)	17527 17555 18036 18041 18042 18055	18070 18077 18092 18951 19087 19310	19344 19362 19363 19464 19504	19505 19512 19520 19525 19543
South Dakota (SD)	57005 57026 57030 57034 57068 57078	57255 57260 57270 57430 57437 57441	57446 57457 57523 57632 57638 57641	57642 57645 57648 57660 57717 57724
Tennessee (TN)	37317	37391	37821	38326

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State	ZIP Code			
Texas (TX)	75007	75851	77430	78613
	75019	75856	77444	78615
	75028	75862	77447	78617
	75044	76008	77450	78620
	75048	76020	77474	78621
	75050	76028	77477	78634
	75051	76036	77480	78641
	75052	76051	77484	78652
	75054	76052	77485	78654
	75067	76063	77489	78657
	75080	76065	77493	78663
	75082	76071	77494	78664
	75088	76092	77511	78669
	75089	76108	77520	78727
	75098	76126	77521	78728
	75104	76177	77532	78729
	75115	76262	77535	78734
	75125	77047	77539	78736
	75146	77053	77546	78737
	75148	77082	77550	78738
	75154	77083	77568	78750
	75159	77085	77581	78759
	75182	77099	77583	78933
	75248	77339	77622	78940
	75252	77357	77656	78950
	75287	77365	77665	78954
	75839	77381	77833	79835
	75844	77382	78610	79922
	75847	77426	78612	79932
Virginia (VA)	20120	20135		
Washington (WA)	98019	98072	98177	99033
	98022	98077	98251	99128
	98047	98092	98354	
Wisconsin (WI)	54540			
Wyoming (WY)	82063	82716	82930	83120
	82082	82725	83114	83127
	82240	82731		

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Additional Information

You can find more information about the use of nine-digit ZIP codes for determining the correct payment locality for anesthesia services and services paid under the MPFS by going to CR 5208, located at http://www.cms.hhs.gov/Transmittals/downloads/R1167CP.pdf.

You might also want to look at updated Medicare Claims Processing Manual, Publication 100-04, Chapter 1 (General Billing Requirements), Section 10.1.1 (Payment Jurisdiction among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services) which you will find as an attachment to this CR on CMS' Web site.

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

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at http://wpc-edi.com/codes. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5456, effective on and after April 1, 2007.**

CMS has also developed a new tool to help you search for a specific category of code and that tool is at http://www.cmsremarkcodes.info. Note that this Web site does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located at http://www.cms.hhs.gov/Transmittals/downloads/R1163CP.pdf.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at* http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf.

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X12N 835 Remittance Advice Remark Code Changes
New Codes

Code	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. **Note: (New Code 12/1/06)**	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. **Note: (New Code 12/1/06)**	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. **Note: (New Code 12/1/06)**	No
N376	Subscriber/patient is assigned to active military duty; therefore primary coverage may be TRICARE. ***Note: (New Code 12/1/06)***	No
N377	Payment adjusted based on a processed replacement claim. **Note: (New Code 12/1/06)**	No
N378	Missing/incomplete/invalid prescription quantity. **Note: (New Code 12/1/06)**	No
N379	Claim level information does not match line level information. **Note: (New Code 12/1/06)**	No

Modified Codes

Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer. **Note: (Modified 12/1/06)**	12/01/06
N181	Additional information is required from another provider involved in this service. **Note: (New Code 2/28/03. Modified 12/1/06)**	12/01/06
N361	Payment adjusted based on multiple diagnostic imaging procedure rules **Note: (New Code 11/18/05. Modified 12/1/06)**	12/01/06

There are NO deactivated codes

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NOTE II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/ regulation.

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

X12 N 835 Health Care Claim Adjustment Reason Codes
New Codes

Code	Current Narrative	Notes
197	Payment denied/reduced for absence of recertification/authorization. **Note: New as of 10/06**	New as of 10/06
198	Payment denied/reduced for exceeded precertification/authorization. **Note: New as of 10/06**	New as of 10/06
199	Revenue code and procedure code do not match. **Note: New as of 10/06**	New as of 10/06
200	Expenses incurred during lapse in coverage. **Note: New as of 10/06**	New as of 10/06
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR). **Note: New as of 10/06**	New as of 10/06

Modified Codes

Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. **Note: Changed as of 10/06 and will be deactivated on 6/1/2007.**	Modified as of 10/06 Effective 6/1/2007

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Code	Current Narrative	Notes
45	Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). **Note: Changed as of 10/06**	Modified as of 10/06 Effective 6/1/2007 **Note: This code replaces code 42 (above) on June 1, 2007.**
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization. **Note: Changed as of 2/01 and 10/06 and will be deactivated on 4/1/2007.**	Modified as of 10/06
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note: Changed as of 2/99 and 10/06.**	Modified as of 10/06
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. **Note: Changed as of 6/03 and 10/06.**	Modified as of 10/06
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). **Note: Changed as of 6/00 and 10/06.**	Modified as of 10/06
196	Claim/service denied based on prior payer's coverage determination. **Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, beginning on that date, value 136 will be used.**	Modified as of 10/06
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). **Note: Changed as of 10/06**	Modified as of 10/06
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated. **Note: Changed as of 2/01 and 10/06.**	Modified as of 10/06
D17	Claim/Service has invalid non-covered days. **Note: This code will be deactivated on 2/1/2007 and code 16 will then be used with appropriate claim payment remark code [M32, M33].**	Modified as of 10/06

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Code	Current Narrative	Notes
D18	Claim/Service has missing diagnosis information. **Note: This code will be deactivated on 2/1/2007 and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].**	Modified as of 10/06
D19	Claim/Service lacks Physician/Operative or other supporting documentation. **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].**	Modified as of 10/06
D20	Claim/Service missing service/product information. **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M19, M20, M67, MA67].**	Modified as of 10/06
D21	This (these) diagnosis(es) is (are) missing or are invalid **Note: New as of 6/05. This code will be deactivated on 2/1/2007.**	Modified as of 10/06

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Financial FAQs

1. Why does the IVR provide a different check date than what I see on remittance notices?

- With the implementation of the Healthcare Integrated General Ledger Accounting System (HIGLAS) in December 2006, financial documents, like electronic funds transfers, provider remittances and checks, etc., will reflect the mail date, not the date the document was created. This change does not affect the claims payment floor.

2. Why does only one Financial Control Number (FCN) show up on my remittance, when previously there was a listing of all the FCNs included in a withholding?

- Prior to our transition to the Healthcare Integrated General Ledger Accounting System (HIGLAS), each overpayment was given its own accounts receivable number. With the transition to HIGLAS in December 2006, withholdings are applied to any outstanding accounts receivables for your provider number that are over 40 days old.
- This means that for a short period of time you will need to combine your accounts receivable notices to determine all the FCN's applied to a withholding. We strongly encourage you to save overpayment letters and set up a system to track all of outstanding accounts payable. We also encourage you to set up a system that will identify all patients included in each outstanding receivable.

3. Can I still request an immediate offset? If so, what is the process?

- Yes, you can still request an immediate offset. When you receive a request from the financial department that will require a refund, you can avoid accruing interest and the possibility of checks "crossing in the mail" by requesting an immediate offset. To request an immediate offset, fax your request on office letterhead to "Immediate Offset" at 1-614-473-6806, with the following information:
  - Letter Number, Accounts Receivable Number (AR), Correspondence Control Number (CCN) or any other identifying number located on the front page of your overpayment letter.
  - The name of the person requesting the immediate offset. This person should be authorized to make the financial decision to request an immediate offset from future Medicare payments due your office.
  - Authorized person's telephone number.
- As a reminder, the above fax number is ONLY for immediate offsets. If you do not agree that an overpayment has occurred or you dispute the amount of the overpayment, send your request in writing to:

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

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4. Why is the requested amount on the letter different than what you are actually withholding?

There are two possible reasons why this may happen:
- Interest may be applied to refunds that are not received or credited to the outstanding overpayment within 40 days of the original overpayment letter, or
- The Healthcare Integrated General Ledger Accounting System (HIGLAS) combines all outstanding accounts receivables for your provider number that are over 40 days old.

5. When multiple patients are included in an overpayment situation, how do I know the reason for the overpayment?

- With all overpayment letters, we will attach a spreadsheet indicating the reason for the overpayment and the names of the patients involved.

6. What does Forwarding Balance mean?

Forwarding Balance means: A negative value represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous RA. A reference number (the original ICN and HIC) is applied for tracking purposes.

What does that mean?
- A negative value represents a "balance that will be moved forward to a future remittance payment advice". This means that an overpayment for a specific claim or claims (on this remittance) has been created because Medicare has paid for a service that should not have been allowed or has paid too much for a service. Your remittance notice will show the corrected allowed amounts for the adjusted claim(s).

- A positive value represents a "balance that is being applied from a previous remittance advice". This means we are notifying you that we have completed an adjustment on a claim or claims (included in this remittance) and we have determined that an additional payment is due in part or in full for a previously processed service(s). Your remittance notice will show the corrected allowed amounts for the adjusted claim (s). A reference number (the original ICN and HIC) will be provided for tracking purposes.

7. Why is it taking so long to credit my refund check?

- With the transition to the Healthcare Integrated General Ledger Accounting System (HIGLAS) in December 2006, refund check credits are taking longer than usual. We are working as quickly as possible to credit your refund amounts to your outstanding overpayments.
- If we offset money from one of your remittance notices and you have already sent us a refund, we will check to see if you have any outstanding overpayments for your tax identification number that are over 40 days old. If you do not have outstanding accounts receivable for your tax identification number, we will refund your money.

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Traumeel Injections: Not covered

Palmetto GBA has determined that the injection of Traumeel, a homeopathic formulation, into the soft tissues, ligaments or other structures of the foot or ankle is not medically necessary. There are no published studies on Traumeel injections in humans in the peer-reviewed literature.

- CPT codes 20550-20553 will be denied if the material injected is determined to be Traumeel.
- HCPCS code J3490 will be denied when used to denote Traumeel.

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Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 7.0

Provider Action Needed

Impact to You

CMS has released the summary of changes reflected in the Health Care Provider Taxonomy Code (HPTC) list version 7.0. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on April 1, 2007.

What You Need to Know

The Health Insurance Portability and Accountability Act (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant.

What You Need to Do

Please review the information included here and stay current on all HIPAA requirements to assure timely processing of your claims.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. The Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction.

HIPAA requires that submitted data, which is part of a named code set, must be valid data from that code set. The health care provider taxonomy is a named code set in the 837 professional implementation guides and carriers must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTCs are updated twice per year, in April and October. The summary of changes for Version 7.0 is noted in the table below:

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TYPE OF CHANGE	PROVIDER TAXONOMY VALUE CODE
Additions	• 207LH0002X • 207PH0002X • 207QH0002X • 202C00000X • 207RH0002X • 207VH0002X • 2080H0002X • 202K00000X • 2081H0002X • 2084D0003X • 2084H0002X • 2084P0015X • 2085D0003X • 2085H0002X • 2086H0002X • 102L00000X • 103TH0004X • 103TP0016X • 111NI0013X • 172M00000X • 172P00000X • 222Q00000X • 242T00000X • 247ZC0005X
Revisions	• 207Q00000X • 2084P0802X • 2084P0804X • 2084N0600X • 2084F0202X • 2084P0805X • 2084N0400X • 2084N0402X • 2084P0800X • 2084V0102X • 103G00000X • 103T00000X • 103TB0200X • 103TC2200X • 103TP2701X • 251S00000X

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TYPE OF CHANGE	PROVIDER TAXONOMY VALUE CODE
Inactivation (will be deleted in future version)	• 103GC0700X • 103TE1000X • 103TM1700X • 103TW0100X • 103TP2700X

The HPTC code list is available from the Washington Publishing Company at http://www.wpc-edi.com.

If you have any questions regarding this article, feel free to call the OH / WV EDI Technical Support help line at 1-866-308-5438.

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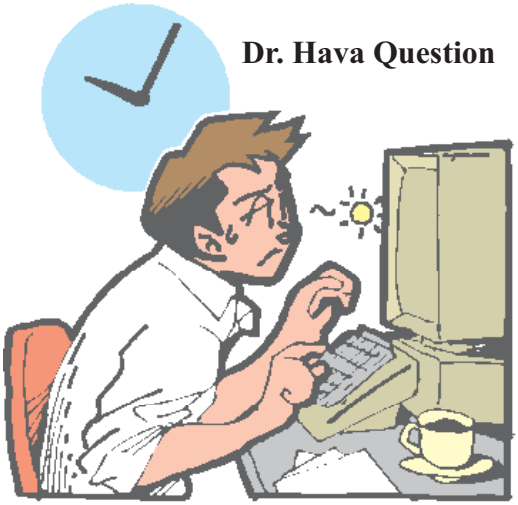
Palmetto Place

Dr. Hava Question



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

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

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

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

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Medicare Part B Small Provider Forum: Medina, Ohio

Palmetto GBA is sponsoring a General Medicare Part B Seminar in Medina, Ohio designed for small providers. This forum is specifically designed for providers with fewer than 10 full time employees. The session will include Medicare updates and reimbursement changes and be followed up with a question and answer session. All specialties are welcome!

Date: Wednesday, March 14, 2007

Location: Buckeye Community Library
6625 Wolff Road
Medina, Ohio 44256

Topics and Time: Medicare Updates (1:00 PM – 3:00 PM)

How to Register - The Medina Area Small Provider Forum
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
- Select Workshops

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

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

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

Please review your schedule and sign up today!

Continued on next page

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Registration Form: Palmetto GBA Small Provider Forums

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

Name: _____

Practice Name: _____

Practice Address: _____

_____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

_____ March 14, 2007, Medina, OH

Name and number of persons attending: _____

To Be Completed by Palmetto GBA

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

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

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

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

Date: March 15 (Thursday) and March 16 (Friday) 2007

Time: 8:00 AM to 4:30 PM

This is an excellent opportunity for you to meet with a Community Education Administrator… one-on-one! Obtain individualized education to address the Medicare concerns that your office may have. Please note: if you are requesting an individual appointment, you must submit your request for an appointment by March 8, 2007. Fax all topics and questions to be discussed during the appointment to 614-473-6812.

A Palmetto GBA representative will contact you by March 9, 2007, to confirm the time and location of your appointment or to make alternate arrangements.

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

Complete the Meeting Fax form on the next page and fax the form to 614-473-6812.

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

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

Meeting Date and Time of Day Requested:

Date	Start Time	End Time
_____	_____	_____

Optional Dates and Times:

Date	Start Time	End Time
_____	_____	_____
_____	_____	_____

Group/Individual Sponsoring Event _____

Contact Person _____ Contact Phone _____ Fax _____

E-mail _____ Registration Web Address _____

Meeting Facility _____

Meeting Facility Address _____

City _____ State _____ Zip Code _____

Facility Phone _____

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

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

_____

_____

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

_____

_____

Requested Agenda Topics

_____

_____

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

Meeting Open _____ Closed _____

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Free Evaluation & Management Medicare Part B Seminars

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

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

Ohio Seminars

Date	Location	Time
Wednesday, May 16, 2007	Holiday Inn 5513 Milan Rd. Sandusky, Ohio 44870	9:00 a.m. – 12:00 p.m.
Wednesday, August 1, 2007	Holiday Inn/Muskingum Valley Conference Center 4645 East Pike Zanesville, Ohio 43701	9:00 a.m. – 12:00 p.m.

West Virginia Seminars

Date	Location	Time
Wednesday, May 30, 2007	Brier Inn 540 N. Jefferson St. Lewisburg, WV 24901	9:00 a.m. – 12:00 p.m.
Wednesday, August 29, 2007	Clarion Hotel & Conference Center 233 Lowe Drive Shepherdstown, WV 25443	9:00 a.m. – 12:00 p.m..

Registration:

To Register for a seminar go to:

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

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

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

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Free Physical Medicine & Rehabilitation Medicare Part B Seminars

Palmetto GBA is presenting a FREE seminar on Physical Medicine and Rehabilitation in Ohio designed for physicians, residents, and health professionals. Education staff from Palmetto GBA will provide the latest Medicare guidelines for selecting and documenting the appropriate level of Evaluation & Management (E/M) codes.

In addition to E/M, we will address the following topics:

- Comprehensive Error Rate Testing (CERT)
- National Provider Identifier (NPI)
- CPT Modifiers 24 & 25
- Correct Coding Initiative (CCI)
- Competitive Acquisition Program (CAP) for Drugs and Biologicals
- Therapy Caps
- Local Coverage Determinations (LCDs), including Trigger Point Injections, Neuromuscular Electrodiagnostic Testing, Chemodenervation, and Paravertebral Facet Joint Blocks
- Other Medicare news

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

This seminar has been approved for Continuing Education Units (CEUs) by the American Academy of Professional Coders (AAPC).

Date	Location	Time
Friday, March 23, 2007	Leo Yassenoff Jewish Community Center 1125 College Avenue Columbus, Ohio 43209	9:00 a.m. – 4:00 p.m.

Registration:

To Register for a seminar go to:

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

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

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

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Reimbursement: How Is It Calculated?

The purpose of this article is to explain how the Medicare Physician Fee Schedule (MPFS) amount is calculated.

Methodologies

Medicare Part B contractors and the Centers for Medicare & Medicaid Services (CMS) use several methodologies to calculate reimbursement. The allowance for procedures submitted to Medicare may be based on:

- Clinical laboratory fee schedule: http://www.cms.hhs.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage
- Drug and biological fee schedule, including Average Sales Price information: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#topofpage
- Medicare Physician Fee Schedule (MPFS): http://www.cms.hhs.gov/PFSlookup/
- Ambulance Fee Schedule (AFS): http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage
- Carrier pricing (applies to services with status indicator C , as listed in the Medicare Physician Fee Schedule Database, or MPFSDB): published on our Web site, for codes that have established (set) prices:
  - Ohio: http://www.PalmettoGBA.com/boh/fees
  - West Virginia: http://www.PalmettoGBA.com/bwv/fees

Medicare Physician Fee Schedule (MPFS)

- CMS calculates the physician fee schedule payment amounts and releases them to carriers in the Medicare Physician Fee Schedule Database (MPFSDB). The MPFSDB is updated periodically throughout the year.
- These fee schedule amounts are calculated according to a formula established by Congress.
- Physicians may provide feedback to CMS on payment and other national Medicare issues through national, state or local medical or specialty societies; for example:
  - Society of Cardiovascular and Interventional Radiology
  - American College of Radiology
  - Radiology Business Management Association
  - American Healthcare Radiology Administrators
  - American Medical Association

Calculating the MPFS

- The fee schedule amount is the product of 3 numbers: RVU (Relative Value Units), GPCI (Geographic Practice Cost Index), and the CF (Conversion Factor).
  - RVUs are established for physician work, practice expense (PE), and malpractice. For 2007, work RVUs are reduced by the Budget Neutrality (BN) factor, which is published in the Federal Register.
  - GPCIs are established to adjust each RVU component geographically.

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- The Conversion Factor is a national number established by Congress.
- RVUs, GPCIs, and the CF are published in the Federal Register.
- For 2007, radiology services may be subject to additional reductions.
  - CMS has modified the multiple procedure payment reduction to the technical component of certain diagnostic imaging procedures.
  - CMS has also implemented a procedure-specific payment cap on the technical component payment of imaging procedures effective January 1, 2007, as required by the Deficit Reduction Act of 2005.
  - For additional information on reimbursement for radiology services, please refer to MLN Matters article SE0665: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0665.pdf

Work RVUs x Budget Neutrality (BN) Factor x Work GPCIs (times)	**PE RVUs x PE GPCIs (times)**	**Malpractice RVUs x Malpractice GPCIs**	**x CF**
Physician work • Time required to render service • Mental and physical effort (intensity) of service • Technical skills required • Relative risk to patient • For 2007 dates of service, the work component is reduced by the BN factor	*Practice overhead expenses* • Office rent • Salaries of office staff • Supplies, etc.	*Malpractice premiums*	

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Examples:

CPT code/CPT modifier 71010-26, facility setting, West Virginia

	Work	Practice Expense	Malpractice	Total RVU	CF	MPFS Amount
RVU (x BN for work component)	0.18 x 0.8994 = 0.16	0.06	0.01	0.22442	37.8975	$8.50
GPCI (for component)	1.000	0.82	1.522			
Total Value	0.16	0.0492	0.01522			

CPT code 20550, non-facility setting, Ohio

	Work	Practice Expense	Malpractice	Total RVU	CF	MPFS Amount
RVU (x BN for work component)	0.75 x 0.8994 = 0.67	0.69	0.09	1.4008	37.8975	$53.0868
GPCI (for component)	1.000	0.934	0.96			
Total Value	0.67	0.64446	0.0864			

Other Notes About the MPFS

- Anesthesia services are priced differently from other CPT and HCPCS codes. Reimbursement for anesthesia services is calculated using a special anesthesia conversion factor, which is also published in the Federal Register.
- The MPFS is used as the basis for calculating reimbursement for other provider types besides physicians.

Provider Type	Basis for Calculating Reimbursement
Physician Assistant	Lesser of: • 80% of submitted charge, OR • 85% of MPFS
Nurse Practitioner	Lesser of: • 80% of submitted charge, OR • 85% of MPFS
Clinical Nurse Specialist	Lesser of: • 80% of submitted charge, OR • 85% of MPFS

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Provider Type	Basis for Calculating Reimbursement
Clinical Nurse Midwife	65% of MPFS
Clinical Psychologist	100% of MPFS
Clinical Social Worker	75% of Clinical Psychologist rate (same as 75% of MPFS)

Fee Schedule Answers!

- How can I find out the current fee schedule amount in the MPFS for a particular CPT code?

Option 1: go directly to the CMS Web site: http://www.cms.hhs.gov/PFSlookup/

Option 2: access the Palmetto GBA Web site (http://www.PalmettoGBA.com/fees for Ohio, or http://www.PalmettoGBA.com/bwv/fees for West Virginia); select Fee Schedules, 2007. Be sure to access the most current version of the fee schedule.

Tip: Search the Excel version of the fee schedule by hitting "Control" and "F," then type in the CPT or HCPCS code.

- What if my code is not listed in the MPFS?

1) Your code may be priced on a fee schedule other than the MPFS. Check the other fee schedules, if appropriate, to locate the reimbursement amount. (Reference the list at the beginning of this article.)
2) Your code may be designated as "carrier priced" in the MPFS, which means that the MPFS will not contain a fee schedule amount. Carrier priced codes are listed in the 2007 Coding & Reimbursement Update, which is available on our Web site under the link to *Medicare Advisories*.

Tip: Some carrier priced amounts are available on the Palmetto GBA Web site. See Option 2 (above) for Web site addresses.

- How does Palmetto GBA communicate changes in the fee schedule?

Changes are made in the fee schedule throughout the year, most often on a quarterly basis. When a change is made in a fee schedule amount or another aspect of the MPFS, Palmetto GBA publishes the information in the *Medicare Advisory* and on our Web site, usually in the form of a *MLN Matters* article. We will also post the updated information on the Fee Schedules pages of our Web site.

If the entire fee schedule changes, Palmetto GBA will republish the complete list of procedure codes/modifiers and MPFSDB indicators.

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Tip: Be the first to know about these changes…register to receive email notifications by accessing http://www.PalmettoGBA.com and select Email Updates.

- Can I ask for payment adjustments if the fee schedule changes in the middle of the calendar year?

When a fee schedule change is made mid-year, the change will be published in the *Medicare Advisory* and on our Web site, and is also communicated via *MLN Matters* articles. At the time that Medicare contractors are officially notified of fee schedule changes, CMS instructs carriers how adjustments may be made. Most commonly, providers must submit redetermination requests for payment adjustments. It is important to refer to *MLN Matters* articles and other educational information published by Palmetto GBA to find out specific instructions about requesting adjustments for each change that is made.

Resources

- CMS *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 23: http://www.cms.hhs.gov/manuals/IOM/list.asp
- To access all CMS *MLN Matters* articles: http://www.cms.hhs.gov/MedlearnMattersArticles/
- For MPFSDB indicators and prices, refer to the CMS Web site: http://www.cms.hhs.gov/PFSlookup/

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2007 Medicare Physician Fee Schedule Database (MPFSDB): Additional Changes

Background

This article and Change Request (CR) 5498 wants providers to know that payment files were issued to carriers based upon the December 1, 2006, MPFS Final Rule and Transmittal 1143, Change Request 5459, *Emergency Update to the 2007 Medicare Physician Fee Schedule Database*. (MM5459, is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf) This CR 5498 **amends those payment files** and **includes new** outpatient prospective payment system (OPPS) **payment amounts for codes subject to the OPPS cap and other miscellaneous corrections.**

Important information regarding the OPPS cap: Reimbursement for services affected by the OPPS cap will reflect updated cap amounts beginning with claims processed on February 26, 2007 (for 2007 dates of service). Reimbursement for claims processed before this date reflects the previous OPPS pricing cap amount.

- Refer to the Palmetto GBA Fee Schedule Web pages for OPPS pricing caps that will be used beginning with claims processed on February 26, 2007, for 2007 dates of service.
- Your reimbursement may be different for claims processed prior to this date. Palmetto GBA will adjust claims brought to our attention; however, we will not search our files for claims affected by these changes in order to retract payment for claims already paid or retroactively pay claims.
- The CMS Medicare Physician Fee Schedule Database (MPFSDB) reflects the updated OPPS cap amounts. The database is available on the CMS Web site: http://www.cms.hhs.gov/PFSlookup/

Key Points of CR 5498

The changes to the 2007 MPFSDB are listed in **Attachment 1** of CR 5498 and those changes are:

CPT Code/Modifier	Action
31545	Bilateral Indicator = 1
31546	Bilateral Indicator = 1
70555 – 26	Work RVU = 2.54
76998 – 26	Work RVU = 1.20
77013 – 26	Work RVU = 3.99
77022 – 26	Work RVU = 4.24
77055 – Global	Work RVU = 0.70
77055 – 26	Work RVU = 0.70

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CPT Code/Modifier	Action
93624 – 26	Status Indictor = A Work RVU = 4.80 Transitional Non-Facility PE RVU = 2.31 Fully Implemented Non-Facility PE RVU = 2.67 (Informational Only) Transitional Facility PE RVU = 2.31 Fully Implemented Facility PE RVU = 2.67 (Informational Only) Malpractice RVU = 0.33
96020 – 26	Work RVU = 3.43
HCPCS Code	**Action**
G0103	Short Descriptor = PSA screening
S0147	Status Indicator = I
S0180	Status Indicator = I
S0345	Status Indicator = I
S0346	Status Indicator = I
S0347	Status Indicator = I
S2325	Status Indicator = I
S2344	Status Indicator = I
S3855	Status Indicator = I

Note: In addition to the changes listed above, all records subject to the OPPS payment cap are also included since these payment amounts have been changed. These codes can be identified by OPPS indicator = 1.

Effective January 1, 2007, for services performed on or after February 26, 2007, the Centers for Medicare and Medicaid Services (CMS) have made changes to the following CPT codes and CPT codes with CPT modifiers on the 2007 Medicare Physician Fee Schedule Database (MPFSDB).

The following are revisions to the current MPFSDB:

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		Non-Facility Setting			Facility Setting		
CPT Code & Modifier	**State**	**PAR**	**NON PAR**	**LMT CHG**	**#F PAR**	**#F NON PAR**	**#F LMT CHG**
70555-26	OH	$115.89	$110.10	$126.62	$115.89	$110.10	$126.62
	WV	$115.13	$109.37	$125.78	$115.13	$109.37	$125.78
76998-26	OH	$59.46	$56.49	$64.96	$59.46	$56.49	$64.96
	WV	$60.55	$57.52	$66.15	$60.55	$57.52	$66.15
77013-26	OH	$187.55	$178.17	$204.90	$187.55	$178.17	$204.90
	WV	$185.90	$176.61	$203.10	$185.90	$176.61	$203.10
77022-26	OH	$200.55	$190.52	$219.10	$200.55	$190.52	$219.10
	WV	$199.87	$189.88	$218.36	$199.87	$189.88	$218.36
CPT Code	**State**	**PAR**	**NON PAR**	**LMT CHG**	**#F PAR**	**#F NON PAR**	**#F LMT CHG**
77055	OH	$74.58	$70.85	$81.48	$74.85	$70.85	$81.48
	WV	$70.71	$67.17	$77.25	$70.71	$67.17	$77.25
CPT Code & Modifier	**State**	**PAR**	**NON PAR**	**LMT CHG**	**#F PAR**	**#F NON PAR**	**#F LMT CHG**
77055-26	OH	$32.75	$31.11	$35.78	$32.75	$31.11	$35.78
	WV	$32.44	$30.82	$35.44	$32.44	$30.82	$35.44
*93624-26	OH	$257.49	$244.62	$281.31	$257.49	$244.62	$281.31
	WV	$254.54	$241.81	$278.08	$254.54	$241.81	$278.08
96020 -26	OH	$153.35	$145.68	$167.53	$153.35	$145.68	$167.53
	WV	$153.26	$145.60	$167.44	$153.26	$145.60	$167.44

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

Note: CPT code/modifier 93624-26 was changed from a status 'C' to 'A'.

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STATUS INDICATORS DEFINED:

A = Active code. These codes are separately paid under the physician fee schedule, if covered. There are RVUs and payment amounts for codes with this status.

C = Carrier code. Carriers price the code. Carriers establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

Providers take note that the Medicare contractors will not search their files for claims affected by these changes in order to retract payment for claims already paid or retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

You can see the official instruction issued to your Medicare carrier, FI or A/B MAC by going to CR 5498, located at http://www.cms.hhs.gov/Transmittals/downloads/R1161CP.pdf.
If you have any questions, please contact our office at 1-877-567-9232.

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Frequently Asked Questions: Locum Tenens and E/M Second Opinions

If there is a time lapse in the locum tenens arrangement, what is the minimum number of days before another 60 days can begin?

Answer: The Centers for Medicare & Medicaid Services (CMS) does not address how long the break must be. Therefore, it could be one or more days. An example of a break in the locum tenens may be if the physician returns for a short period then leaves again.

Additional information is available at the following address:

- The CMS Medicare Claims Processing Manual (Pub. 100-02), chapter 1, section 30.2.11: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf
- Palmetto GBA Web site at http://www.PalmettoGBA.com/boh/guide (for Ohio) or http://www.PalmettoGBA.com/bwv/guide (for West Virginia), then click on "Locum Tenens & Reciprocal Billing."

What are the guidelines for submitting claims for second opinions?

Answer: A second opinion E/M service is a request by the patient and/or family or mandated (e.g., by a third-party payer) and is not requested by a physician or qualified nonphysician practitioner (NPP). A consultation service requested by a physician, qualified NPP or other appropriate source that meets the requirements shall be reported using the initial consultation service codes. A written report is not required to be sent to a physician when an evaluation for a second opinion has been requested by the patient and/or family. Second opinions in an office at the request of the patient or family are submitted with the office or other outpatient visit E/M codes, not consultation codes. Second opinions in a hospital or nursing facility at the request of the patient or family are submitted in the same manner.

In both the inpatient hospital setting and the nursing facility (NF) setting, a request for a second opinion would be made through the attending physician or physician of record.

Additional information is available in the following locations:

- CMS Medicare Claims Processing Manual, Chapter 10 –Section 30.6.1B, located at: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf.
- You may also refer to the CMS Medicare Benefit Policy Manual, Chapter 15, section 30.C located at: http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf
- Palmetto GBA Web site at http://www.PalmettoGBA.com/boh/guide (for Ohio) or http://www.PalmettoGBA.com/bwv/guide (for West Virginia).

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Colorectal Cancer Screening Flexible Sigmoidoscopy & Colonoscopy Coinsurance Payment Change

Impact on Providers

Effective for services on or after January 1, 2007, Medicare requires:

1. A 25% beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies, and colonoscopies performed in the outpatient departments of non-Outpatient Prospective Payment System (non-OPPS) hospitals; and
2. A 25% beneficiary coinsurance for colorectal cancer screening colonoscopies performed in ambulatory surgery centers (ASC).

Background

Section 1834(d)(2) of the Social Security Act, imposes a 25% beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies (*HCPCS code G0104-Colorectal cancer screening; flexible sigmoidoscopy*) that are performed in hospital outpatient departments. *While this coinsurance has already been applied in the Outpatient Prospective Payment System (OPPS) for OPPS hospitals (*effective for services performed on or after January 1, 1999), *it will now be applied to non-OPPS hospitals, effective January 1, 2007.*

Similarly, Section 1834(d)(3) of the Social Security Act, in part, imposes a 25% beneficiary coinsurance for colorectal cancer screening colonoscopies (*HCPCS codes G0105 - Colorectal cancer screening; colonoscopy on individual at high risk, and HCPCS code G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*) that are performed in Ambulatory Surgical Centers (ASCs) and in hospital outpatient departments. And while, as above, this coinsurance has already been applied in the Outpatient Prospective Payment System (OPPS) for OPPS hospitals (effective for services performed on or after January 1, 1999), it is being applied to these services performed in ASCs or non-OPPS hospitals, effective January 1, 2007.

Therefore, effective for services on or after January 1, 2007 (as is currently done for OPPS hospitals), FIs, Carriers, A/B Macs will apply the 25% coinsurance to colorectal cancer screening flexible sigmoidoscopies (HCPCS code G0104) and colonoscopies (HCPCS codes G0105 and G0121) that are performed in non-OPPS hospitals and to colorectal cancer screening colonoscopies (HCPCS codes G0105 and G0121) that are performed in ASCs.

Pertinent details included in CR 5387 are:

- For services beginning January 1, 2007, FIs, carriers, A/B MACS will base the coinsurance amounts for colorectal screening sigmoidoscopies and colonoscopies, performed in non-OPPS hospitals, on the payment methodology currently in place for colorectal screening services and, for those performed in ASCs, on Medicare's ASC facility payment for services.

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- FIs, carriers, and A/B MACs will neither search for nor adjust claims for colorectal screening colonoscopies and sigmoidoscopies that have been paid prior to the implementation of this change by Medicare on July 2, 2007, but they will adjust such claims that are brought to their attention.

- While prior to January 1, 2007, both a deductible and a coinsurance applied to these colorectal screening procedures, effective for services on or after January 1, 2007 **(as part of Section 5113 of the Deficit Reduction Act [DRA]), the deductible is waived for colorectal screening sigmoidoscopies and colonoscopies performed in ASCs or hospital outpatient departments.**
  This change is implemented under CR 5127, transmittal 1004, dated July 21, 2006. A related *MLN Matters,* MM 5127, is available on CMS' Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf.)

- For procedures performed in ASCs, this change applies to the ASC bills, not to the physician bills.

- FIs, carriers, and A/B MACs will change the Medicare Explanation of Benefit (EOB) notices issued to beneficiaries to reflect this change in the coinsurance/copayment amount. They will use EOB message 61.41 – "You pay 25% of the Medicare-approved amount for this service."

Additional Information

You can find more information about the change in the coinsurance payment amount for colorectal cancer screening flexible sigmoidoscopy and colonoscopy performed in hospital outpatient departments and ASCs, by going to CR 5387, located on CMS' Web site at http://www.cms.hhs.gov/Transmittals/downloads/R1160CP.pdf. Attached to the CR 5387, you will find updated *Medicare Claims Processing Manual* (Publication 100-04), Chapter 1 (General Billing Requirements), Section 30.3.1 (Mandatory Assignment on Carrier Claims); Chapter 14 (Ambulatory Surgical Centers), Section 40.2 (Carrier Adjustment of Base Payment Rates); and Chapter 18 (Preventive and Screening Services), Sections 60.1 (Payment), 60.1.1 (Deductible and Coinsurance); and 60.2.2 (Ambulatory Surgical Center [ASC] Facility Fee).

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

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Non-Physician Practitioner (NPP) Services Furnished to Hospital Inpatients and Outpatients: Direct Billing and Payment

Background

Section 4511(a)(2)(B) of the Balanced Budget Act of 1997 amended section 1861(b)(4) of the Social Security Act **to exclude the professional services of NPs, CNSs and PAs from hospital inpatient services**. Accordingly, upon the effective date of Change Request (CR) 5221, NPs and CNSs are authorized to bill Medicare carriers directly for their professional services when furnished to hospital patients, both inpatients and outpatients. The **employer of a PA**, rather than the hospital, **must bill the carrier for their professional services when furnished to hospital patients**. **Hospitals should not bill for the professional services of a PA, unless the PA is employed by the hospital.**

Key Points

This article and Change Request (CR) 5221 describe the removal of the paragraph in the *Medicare Claims Processing Manual*, Chapter 12 section 120.1 that contains outdated policy on payment for NP and CNS services furnished in a hospital setting. The changes are as follows:

> The professional services of NPs and CNSs furnished to hospital inpatients and outpatients may be billed directly by the NP or CNS to the carrier under their respective Medicare billing number or their National Provider Identifier (NPI), once the NPI is effective.

The employer of a PA may bill the carrier directly for the professional services of the PA furnished to hospital inpatients and outpatients under the PA's Medicare billing number or the PA's NPI, once the NPI is effective.

Hospitals may bill the carrier for the professional services of an NP or a CNS furnished to hospital inpatients and outpatients when payment for the NP and CNS services has been reassigned to the hospital and when the hospital bills for these services under the NP's or CNS's Universal Provider Identifier Number (UPIN).

Your Medicare carrier will identify and reprocess any claims submitted by NPs, CNSs, or the employer of a PA that have been denied since January 1, 2006, because the claim listed a hospital inpatient or outpatient setting place of service.

For claims for dates of service prior to January 1, 2006, the carrier will reopen claims that were denied because they listed a hospital inpatient or outpatient place of service. However, the carrier will only reopen these claims if the NP, CNS, or employer of the PA brings the claim to the attention of the carrier and the carrier will pay these claims for dates of services on or after the January 1, 1998, effective date retroactive to the actual date that the services were rendered.

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Additional Information

The official instructions, CR 5221, issued to your Medicare carrier regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R1168CP.pdf on CMS' Web site. A revised Chapter 12, Section 120.1—Direct Billing and Payment—of the *Medicare Claims Processing Manual* is attached to CR 5221.

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

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Ambulance Providers: CMS-1491 Form

Effective **April 2, 2007**, ambulance suppliers will no longer be permitted to submit paper claims on CMS-1491 claim forms. These forms received by Palmetto GBA on or after April 2, 2007, will be returned with an unprocessable letter.

Ambulance suppliers MUST re-submit rejected claims on the CMS-1500 claim form (Version 08/05) or re-submit them electronically for processing for payment.

Providers must refer to the *November 2006 Medicare Advisory* for instructions on how to complete a CMS-1500 claim form. Providers may also view the CMS directive (CR 5390) at http://www.cms.hhs.gov/transmittals/downloads/R1144CP.pdf.

Frequently Asked Question: ESRD Ambulance Transports

Do I need to submit an ambulance transport for all new ESRD patients as a 'parent claim'?

Answer: No. If the ESRD patient is new to you, then you should first call the Provider Contact Center to verify if the patient has a coverage period already established for this transport. If the dates of service fall within the coverage already established then the claim to be submitted should NOT be submitted as a parent claim, nor should it have the words "fax," "status change," or "see fax" etcetera in the comments field. This claim is simply a subsequent claim, and when submitted correctly will process without any delays or review. Remember, coverage periods are established for the beneficiary, not for the ambulance company; therefore, even if the beneficiary is new to the ambulance company, he or she may already have a coverage period established.

Additional information (including documentation instructions) is available on our Web site: http://www.PalmettoGBA.com/boh (for Ohio) or http://www.PalmettoGBA.com/bwv (for West Virginia), then click on "Ambulance."

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Alcohol Septal Ablation for Hypertrophic Obstructive Cardiomyopathy

The following instructions are effective for dates of service on or after February 1, 2007.

CPT code 0024T:

- Report CPT code 0024T for non-surgical septal reduction therapy (e.g., alcohol ablation), for hypertrophic obstructive cardiomyopathy (ICD-9 code 425.1).

- Coronary arteriograms and temporary pacemakers are included when reporting this code.

- The ethanol and administration may be reported separately in conjunction with the AISA (alcohol induced septal ablation) procedure.

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Endovascular Repair of Abdominal Aortic Aneurysm

The following guidelines are effective for dates of service on or after February 1, 2007.

CPT codes 0078T - 0081T:

- CPT codes 0078T and 0079T are intended to report endovascular repair of abdominal aortic aneurysm, pseudoaneursym or dissection involving visceral vessels (superior mesenteric, celiac and/or renal artery) using a fenestrated modular bifurcated prosthesis (two docking limbs).

- CPT code 0078T is intended to be reported for deployment of the main fenestrated aortic device.

- CPT code 0079T is intended to be reported as a separate add-on code for deployment of each visceral extension prosthesis.

- CPT code 0080T is intended to report radiological supervision and interpretation services for endovascular repair of abdominal aortic aneurysm involving visceral vessels. Reported for imaging services for placement of the main fenestrated aortic device.

- CPT code 0081T is intended to report radiological supervision and interpretation services for endovascular repair of abdominal aortic aneurysms involving visceral vessels. This code should be reported one time for imaging services for each visceral branch extension.

- CPT codes 0078T - 0081T should be reported in accordance with the Endovascular Abdominal Aneurysm Repair guidelines established for CPT codes 34800-34826.

- CPT codes 0078T - 0081T may be reported in conjunction with CPT codes 35454, and 37205-37208 when these procedures are performed outside the target zone of the endoprosthesis.

- CPT codes 0078T - 0081T should not be reported with CPT codes 34800 - 34805, 35081, 35102, 35452, 35454, 35472, and 37205-37208.

- ICD-9 codes that are covered:
  - 441.4 - abdominal aneurysm without rupture

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Clinical Laboratory Improvement Amendments (CLIA) Edits: HCPCS Codes Subject & Excluded

Provider Action Needed

Impact to You

If you do not have a valid, current, CLIA certificate and submit a claim to your Medicare carrier or A/B MAC for a HCPCS code that is considered to be a laboratory test, your Medicare payment may be impacted.

What You Need to Know

The Clinical Laboratory Improvement Amendments of 1998 (CLIA) requires that for each test it performs, a laboratory facility must be appropriately certified. The HCPCS codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 5457, from which this article is taken, informs carriers and A/B MACS about the new HCPCS codes for 2007 that are subject to CLIA edits and also about those that are now excluded from CLIA edits.

What You Need to Do

Make sure that your billing staffs are aware of these CLIA-related HCPCS changes for 2007 and that you remain current with certification requirements.

Background

The Clinical Laboratory Improvement Amendments of 1998 (CLIA) require a laboratory facility to be appropriately certified for each test it performs.

To ensure that Medicare and Medicaid only pay for laboratory tests that are performed by certified facilities, carriers and A/B MACs will edit each Medicare claim submitted for a HCPCS code considered to be a CLIA laboratory test. These HCPCS codes change each year, and CR 5457, from which this article is taken, informs carriers and A/B MACs about the new HCPCS codes for 2007 that are both subject to, and excluded from, CLIA edits.

The HCPCS codes listed in the Table 1, below, are new for 2007 and are subject to CLIA edits (the list does not include new HCPCS codes for waived tests or provider-performed procedures.) This means that laboratory facilities performing these tests must have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). Conversely, a facility **without** a valid, current CLIA certificate, or **with** a current CLIA certificate of waiver (certificate type code 2) or a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) will not be paid for these tests and the claims will be denied.

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Table 1: New 2007 CPT Codes Subject to CLIA Edits

CPT Codes	Description
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks
17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks
17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)
82107	Alpha-fetoprotein (AFP); APF-L3 fraction isoform and total AFP (including ratio)
83698	Lipoprotein-associated phospholipase A_2, (Lp-PLA_2)
83913	Molecular diagnostics; RNA stabilization
86788	Antibody; West Nile virus, IgM

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CPT Codes	Description
86789	Antibody; West Nile virus
87305	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Aspergillus
87498	Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique
87640	Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique
87641	Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique
87653	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus , group B, amplified probe technique
87808	Infectious agent detection by immunoassay with direct optical observation; Trichomonas vaginalis

CR 5457 also provides HCPCS codes that were discontinued on December 31, 2006.

Table 2: CPT Codes Discontinued in 2007

CPT Codes	Description
17304	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to five specimens
17305	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); second stage, fixed or fresh tissue technique, up to five specimens
17306	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); third stage, fixed or fresh tissue technique, up to five specimens

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CPT Codes	Description
17307	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); additional stage(s), up to five specimens, each stage; and
17310	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); each additional specimen, after the first five specimens, fixed or fresh tissue any stage (list separately in addition to code for primary procedure).

Note: Carriers and A/B MACS will add the LC code of 610 for the specialty of histopathology to the new Mohs CPT codes (17311, 17312, 17313, 17314, and 17315) even though are not currently edited at the laboratory certification (LC) level.

Remember that carriers and A/B MACs will return as unprocessable claims submitted with the CPT codes displayed in Table 1, above, **without** a CLIA number. Also, carriers and A/B MACs will deny payment for claims submitted without a valid current CLIA certificate, or **with** a CLIA certificate of waiver (certificate type code 2), or a CLIA certificate for provider-performed microscopy procedures (certificate type code 4). Finally, carriers and A/B MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to the April 2, 2007, implementation date. They will adjust claims that are brought to their attention.

Additional Information

You can find the official instruction, CR 5457, issued to your carrier or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1165CP.pdf on CMS' Web site.

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

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Computerized Corneal Topography: Referring/Ordering Physician Required

When submitting CPT code 92025 (computerized corneal topography), the name and UPIN or NPI of the referring/ordering physician must be submitted in the designated claim fields.

If submitted without the above information, CPT code 92025 will be rejected and must be resubmitted on a new claim.

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Lumbar Artificial Disc Replacement (LADR): Coding Changes

Provider Action Needed

Impact to You

Effective for services on or after January 1, 2007, the CPT codes for billing LADR are changing.

What You Need to Know

No change in Medicare policy results from this coding change. But, be sure billing staff use the correct codes to assure prompt and correct payment of your claims.

What You Need to Do

For services on or after January 1, 2007, use CPT code 22857 in place of CPT Category III code 0091T for LADR. Also, use new CPT Category III code 0163T in place of CPT Category III code 0092T for services on or after January 1, 2007. CPT Category III codes 0091T and 0092T are still appropriate for services on or before December 31, 2006, but are discontinued as of December 31, 2006.

Background

This article is based on Change Request (CR) 5462 and the purpose is to announce a coding change effective January 1, 2007, for LADR. A prior change request (CR) 5057, transmittal 992, issued on June 23, 2006, contains correct codes for services rendered in 2006. However, beginning with services rendered on or after January 1, 2007, there are new coding changes. If you would like to review the MLN article that resulted from CR 5057 click on the following link: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5057.pdf.

Please be aware that the National Coverage Determination (NCD) issued under CR 5057 is not changing; only the codes that should be utilized have changed.

Effective for services performed on or **after January 1, 2007**, carriers will **deny claims**, for Medicare beneficiaries over sixty years of age, submitted with the following codes:

- CPT code 22857 for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace.
- CPT Category III code 0163T for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace.

Carriers and A/B MACs will continue to follow their normal claims processing criteria for investigational device exemptions (IDEs) for LADR performed with an implant eligible under the IDE criteria.

Carriers will allow claims submitted for approved IDEs/clinical trials submitted with:

- CPT codes 0091T or 0092T for services performed from May 16, 2006 through December 31, 2006.
- CPT codes 22857 or 0263T for services preformed on or after January 1, 2007, with the HCPCS modifier QA.

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Additional Information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR 5462) issued to your Medicare A/B MAC or carrier. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1164CP.pdf.

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Infrared Therapy Devices

Note: This article was revised on February 9, 2007, to correct the range of ICD-9 codes shown in bold print on page 2. The range is 880.00-887.7. Originally, CR 5421 and the related article incorrectly showed 880.00-887.79 for that range. The CR transmittal number, release date, and Web address for accessing CR 5421 are also revised, but all other information remains the same.

Provider Types Affected

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

Impact on Providers

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

Background

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

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

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are non-covered** as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with CPT code 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS codes E0221 or A4639, if they are accompanied by the following ICD-9 codes:
  - 250.60-250.63,
  - 354.4, 354.5, 354.9,
  - 355.1-355.4,
  - 355.6-355.9
  - 356.0, 356.2-356.4, 356.8-356.9,
  - 357.0-357.7,
  - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
  - 707.00-707.07, 707.09-707.15, 707.19,

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- 870.0-879.9,
- **880.00-887.7**,
- 890.0-897.7, or
- 998.31-998.32.

- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an Advance Beneficiary Notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

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

Please see the two transmittals associated with CR 5421 for complete details. The first is the national coverage determination transmittal, located at http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf on the CMS Web site. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf on the CMS site.

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

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

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

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

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

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Local Coverage Determination Updates

LCD	Change	Effective Date
Wireless Capsule Endoscopy **Draft Policy:** 2002-48LR6	Policy Revision: Addition of CPT code 91111 as non-covered service.	4/1/2007

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Medicare Part B Refund & Overpayment Form

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

Provider Information
(Must be Completed)

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

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

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

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

Medicare Secondary Payer Reason For Overpayment

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

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

Medicare Secondary Payer (MSP)

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

Secondary Insurance:

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

Reason For Overpayment/Refund

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

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

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

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

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

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Medicare Opt Out HPSA and/or PSA Bonus Program

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

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

_____

Signature: _____

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

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

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

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

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

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

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

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

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Redetermination Request for Medicare Part B Claims

For Ohio & West Virginia

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

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

General Information

Patient's name _____

Health Insurance Claim (HIC) number _____

Date of initial determination _____

CPT code(s) _____

ICD-9 code(s) _____

Performing provider number _____

Billing provider number _____

Phone number _____

Date of service _____

This is an appeal for:

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

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

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

Reason for request: _____

_____

_____

_____

Requestor (signature required): _____ Date: _____

Address: _____

_____

_____

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

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Reconsideration Request Form - QIC North (Ohio)

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

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

1. Name of Beneficiary: _____

2 a. Medicare Number: _____

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

3. Provider Name and Number: _____

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

5. Address of Person Appealing:

6. Item or service you wish to appeal:

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

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

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

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

11. Printed Name of Person Appealing:

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

13. Phone Number of Person Appealing: _____

Contractor Number: 00883

Palmetto GBA –Ohio Medicare Part B Carrier (Carrier 00883)
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 567-9232
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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 include the bolded information.** Please include a copy of the redetermination notice and identify the claim number 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: _____
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

3. Provider Name and Number: _____

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

5. Address of Person Appealing:

6. **Item or service you wish to appeal:**

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

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

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

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

11. **Printed Name of Person Appealing:**

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

13. **Phone Number of Person Appealing:** _____

Contractor Number: 00884

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

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

TTY 1-877-391-9739

Provider Enrollment Support Line
1-866-308-5439

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

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

http://www.PalmettoGBA.com

Important Sources For You

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

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Attention: Billing Manager

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