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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

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You Are Responsible. . .

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

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

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

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

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

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

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

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Extension for Acceptance of Form CMS-1500 (12-90)

Background

Form CMS-1500 is one of the basic forms prescribed by the Centers for Medicare & Medicaid Services (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 Form CMS-1500 (12-90) was revised in July of 2006 to accommodate the reporting of the National Provider Identifier (NPI).

Recently it came to the attention of CMS that there are incorrectly formatted versions of the revised form being sold by print vendors. After reviewing the situation, CMS determined that the source files received from the authorized forms designer were improperly formatted. This resulted in the sale of printed forms and negatives which do not comply with the form specifications.

Therefore, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. The specific formatting issue involves top and bottom margins only, but may not be isolated to only top and/or bottom.

Key Points of CR 5568

CR 5568 states that the Form CMS-1500 (12-90) will continue to be accepted until CMS instructs otherwise.

All Form CMS-1500 (08-05) forms received by Medicare contractors that are incorrectly formatted will be returned to the provider or supplier if the Medicare contractor is unable to scan the form with its Optical Character Reader scanning equipment. An incorrectly formatted form is one that is ¼” or more off in the top, bottom, right, and/or left margins.

The best way to identify the incorrect forms is by looking at the upper right hand corner of the form. If the tip of the red arrow above the vertically stacked word “CARRIER” is touching or close to touching the top edge of the form, then the form is not printed to specifications. There should be approximately ¼” between the tip of the arrow and the top edge of the paper on properly formatted forms.

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

Additional Information

To see the official instruction (CR 5568) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1208CP.pdf> on the CMS Web site.

To view the original communication from CMS regarding this issue, visit <http://www.cms.hhs.gov/ElectronicBillingEDITrans/downloads/1500%20problems.pdf> on the CMS site.

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

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CMS-1500 Form Submission Requirements: Revisions

Background

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare and Medicaid programs for claims from physicians and suppliers. The language contained in the *Medicare Claims Processing Manual*, Chapter 26, regarding the Form CMS-1500 is being updated to reflect current processing guidelines and incorporate recent data collection decisions made by CMS.

Key Points

CR 5489 makes the following updates to the CMS-1500 requirements:

- The requirement to submit the provider's Social Security Number in Box 25 has been removed;
- The requirement to report the PIN of the Skilled Nursing Facility in Box 23 has been removed; and
- Clarification language was added to Box 17a, indicating the qualifier 1G precedes the Unique Physician Identification Number (UPIN).

In addition, language has been added regarding the completion of Item 25 (the provider of service or supplier federal tax identification number). Medicare providers are not required to complete this item for crossover claim purposes, since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the Coordination of Benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate National Provider Identification (NPI) reimbursement. Thus, reimbursement of claims submitted without tax identification information may be delayed.

Additional Information

CR 5489 is the official instruction issued to your Medicare contractor. Go to <http://www.cms.hhs.gov/Transmittals/downloads/R1215CP.pdf> to view the instruction on the CMS Web site. The revised Chapter 26, section 10.4, of the *Medicare Claims Processing Manual* is attached to CR 5489.

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

Coding on CMS-1500: Clarification of MM 5488 Article

What You Need to Know

This special addition article (SE 0716) clarifies MM 5488 (Temporary Addition to the Administrative Simplification Compliance Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims -- Released March 9, 2007). MM 5488 related to Change Request (CR) 5488, which informed Medicare carriers and A/B MACS that a temporary waiver to a requirement of the Administrative Simplification Compliance Act (ASCA) is being granted for the co-payments in MSP claims.

Specifically, SE 0716 notifies physicians and providers that your claims may be processed in error if you identify the primary payer's primary payment in block 29 of the CMS form 1500. You must only identify and enter the **beneficiary payment amount** in this block.

Background

CR 5488 instructed CMS contractors (carriers and A/B MACs) who use the Medicare Multi-Carrier System (MCS) for claims processing, to grant a temporary ASCA waiver (until July 1, 2007), for Electronic Media Claim (EMC) MSP claims to allow processing of these claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer Managed Care Organization (MCO).

Therefore, until July 1, 2007, carriers and A/B MACs will allow for co-payment reimbursement claims to be submitted on paper and to send reimbursement directly to the beneficiary.

In clarifying MM 5488, this special addition article (SE 0716) notifies physicians and providers, that in order for this temporary exception to be implemented, you must only identify the beneficiary payment amount in block 29 of the CMS form 1500. You must not identify the primary payer's primary payment in this block, or your claims may be processed in error.

Additional Information

You might want to review CR 5488 at <http://cms.hhs.gov/transmittals/downloads/R1194CP.pdf> or MM 5488 at <http://www.cms.hhs.gov/MLNMArticles/downloads/MM5488.pdf> on the CMS Web site.

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

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, which is quite descriptive, is now available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/>.

Background

The CWF displays information on the Medicare Part C (now known as Medicare Advantage) contract number in which a beneficiary is enrolled, including the plan type description associated with the contract, and currently, CWF displays the label “HMO” for these contracts. In many of these cases, the “HMO” label is incorrect because the list of possible plan type descriptions has grown much larger since the creation of the Medicare Advantage (MA) programs.

This situation has especially become problematic for Medicare beneficiaries who are enrolled in MA Private Fee-for-Service (PFFS) contracts because PFFS contracts are labeled as “HMO” in CWF. Consequently, some providers are not recognizing that they can offer services to those beneficiaries enrolled in a MA PFFS contract.

To address this issue, the Health Plan Management System (HPMS) will modify the existing HMO address file exchange process with CWF in order to supply the list of available contract numbers and their corresponding plan type descriptions. With this new data, CWF can correctly display one of the following plan type descriptions: HMO, PPO, POS, Indemnity, or FFS Demo. The following table provides additional information to providers regarding these plan type descriptions:

Plan Type Description	Brief Guidance on Treating Patient	Additional Information
HMO	Call plan for authorization.	Managed Care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.
PPO	You may treat the patient.	Has a network of providers. In return for higher cost sharing, members can go out of the plan network for all plan services, including supplemental benefits.

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Plan Type Description	Brief Guidance on Treating Patient	Additional Information
POS	You may treat the patient subject to plan rules. Contact the plan for details.	A limited out-of-network option offered by HMO plans. Contact plan for details.
Indemnity	You may treat the patient.	If this is a PFFS plan, you must follow the PFFS plan's terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.
FFS Demo	You may treat the patient.	Beneficiaries remain in original Medicare and are entitled to all fee-for-service benefits. There are no changes to Medicare FFS billing instructions or claims processing.

Additional Information

The official instruction, CR 5538, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1219CP.pdf>.

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

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Federal District Court Appeals: Amount in Controversy Requirement

Provider Action Needed

This article is based on Change Request (CR) 5518 which notifies Medicare contractors of an increase in the Amount in Controversy required to sustain Federal District Court appeal rights beginning January 1, 2007.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. Therefore, **CR 5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, Sections 330.1 and 345.1) to announce the Amount in Controversy Requirements for ALJ or Federal District Court Appeals during 2007.**

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006 was \$100. The amount in controversy requirement increased to \$110 for requests made on or after January 1, 2006. **CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at \$110.**

The amount remaining in controversy requirement for Federal District Court review prior to January 1, 2006, was \$1,000. That amount increased to \$1,090 on or after January 1, 2006. **CR 5518 announces that for Federal District Court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to \$1,130.**

Additional Information

The official instruction, CR 5518, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1211CP.pdf>.

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

CERT Audit Findings – Provider Notification Process

Once an error is identified through the Comprehensive Error Rate Testing or CERT program, Palmetto GBA OH/WV is notified. If the findings result in a change to the submitted Medicare Part B claim, the affected services and payment revisions are disclosed to the provider through a Remittance Advice (RA) notice. An overpayment or demand letter may also be generated when applicable.

In the cases where a Medicare overpayment occurred as a result of the CERT review, a nurse in the Provider Outreach and Education (POE) department at Palmetto GBA prepares a separate education letter for each provider. The letter's purpose is to clarify the specific discrepancies, e.g., code/payment reductions and denials identified by the CERT Review Contractor or CRC. They will also include more detailed claim information related to the submitted services, along with the CRC's actual findings and rationale for assessing the error.

Guidelines for filing an appeal and POE contact information are supplied with the letter should questions arise. Supplemental educational materials from Palmetto GBA OH/WV may also be enclosed for reference purposes.

Notice of New Interest Rate for Medicare Overpayments & Underpayments: 3rd Qt. FY 2007

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (four percent for calendar year 2007) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to **12.375 percent** effective **April 20, 2007**.

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Deceased Providers: Provider Education for Handling Related Issues

Provider Types Affected

Those submitting claims on behalf of physicians and providers who died before obtaining a National Provider Identifier (NPI), where such submitted claims that were received by a Medicare contractor (carrier, Part A/B Medicare Administrative Contractors (A/B MAC), durable medical equipment (DMERC) and/or DME Medicare Administrative Contractors, (DME/MAC)) after May 23, 2007.

Background

This article and related Change Request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used.

All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

- Any health care provider who is an entity covered under HIPAA must obtain an NPI.
- Health care providers meeting the definition of health care provider referenced in the NPI final rule but not covered entities are eligible to obtain NPIs as well.
- Health care providers covered under HIPAA must use NPIs to identify themselves and their subparts (if applicable) on all standard transactions adopted under HIPAA.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

Key Points of CR 5508

If an individual provider dies before obtaining an NPI, the following apply:

- A representative of the estate of a proprietor cannot apply for an NPI for that provider posthumously.
- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and **Medicare (the Medicare contractor, the Medicare Online Survey and Certification Reporting System (OSCAR), of the National Supplier Clearinghouse (NSC)) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider's NPI.**

At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. Our toll free number is 1-800-567-9232.

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The State in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some States send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:

- Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
- A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

Additional Information

You may view the official instruction (CR 5508) issued to your Medicare carrier, DME/MAC, DMERC and/or A/B MAC by going to CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf>.

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

New Claim Adjustment Reason Code

New claim adjustment reason code 204 ("This service/equipment/drug is not covered under the patient's current benefit plan") became effective February 28, 2007. Providers may see this new reason code on their remittance notice, instead of 96, effective April 2, 2007.

Please access the CMS Internet Only Manuals for specific coverage information.

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Repeat or Duplicate Services on the Same Day

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

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

When a correction is needed on a previously paid service, do not submit as a new claim. A redetermination request must be submitted in writing to:

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

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

- Submit multiple, identical services on the same claim. If you submit more than one claim for the same service, you can expect identical services to be denied.
- Use the Days/Units Field. Submit services on one claim using the Days/Units field.

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

Example: Patient receives two chest x-rays on 10/1/06 interpreted by the *same physician*. The first interpretation is performed at 10:00 a.m and the interpretation of the second x ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	71010-26	2

Modifiers

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

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Site Modifiers:

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

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

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	28010-T1	1
10/1/06	28010-T3	1

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

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

Example: Patient receives three chest x-rays on 10/1/06 by the *same physician*. The first x-ray is performed at 10:00 a.m., the next one at 12:00 p.m., and a follow-up x-ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	71020	1
10/1/06	71020-76	2

OR submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	71020	3

- The most effective method to ensure timely processing is to use the Days/Units Field and submit all services on one claim.
- **CPT Modifier 77 – “Repeat procedure by another physician”:** A physician may need to indicate that he repeated a service performed by *another physician* on the same day.

Example: Patient receives two EKGs on 10/1/06. The first EKG is taken at 10:00 a.m. and Dr. A performs the interpretation. The second EKG is taken at 1:30 p.m. and Dr. B performs the interpretation.

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Submit as:

Claim #1 – Dr. A

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	93010	1

Claim #2 – Dr. B

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	93010-77	1

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

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

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/06	82746	1
10/1/06	82746-91	1

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Hemophilia Clotting Factors: Billing the Quantity Billed Field (QB)

Submitting the correct Quantity Billed (QB) for hemophilia clotting factors is essential to receiving correct reimbursement. To calculate the correct Quantity Billed, divide the number of International Units (IUs) administered by 100, and round to the nearest whole number. This calculation methodology has been in effect since July 1, 2000.

HCPCS Codes for Hemophilia Clotting Factors:

J7187	J7194
J7189	J7195
J7190	J7198
J7191	J7199
J7192	Q0187 (for dates of service prior to 1/1/06)
J7193	J7188 and Q2022 (for dates of service prior to 1/1/07)

- First dividing the number given by 100 and
- Second, round to the nearest whole number to determine the billing unit.
 - Fractions from .50 to .99 = 1 additional billing unit.
 - Fraction from .01 to .49 = NO additional billing unit.
- Report the result in the units field of the claim form.

The following examples illustrate the correct billing methodology:

Example 1:

A patient received 1232 IU of Factor VIII.

- Divide 1232 by 100 ($1232 \div 100 = 12.32$).
- Providers must round to the nearest whole number (12).
- Report the result (0120) in the units field (item 24G) of the claim form.

Example 2:

A patient received 25778 IU of anti-inhibitor coagulant complex.

- Divide 25778 by 100 ($25778 \div 100 = 257.78$).
- Providers must round to the nearest whole number (258).
- Report the result (2580) in the unit's field (item 24G) of the claim form.

Example 3:

A patient received 5798 IU of Factor IX.

- Divide 5798 by 100 ($5798 \div 100 = 57.98$).
- Providers must round to the nearest whole number (58).
- Report the result (0580) in the unit's field (item 24G) of the claim form.

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Exception:

Not otherwise classified code (NOC) J7199. This code requires the drug name and total IUs submitted (i.e. dosage) in the comment screen for electronic claims. Paper claims must submit this information in Item 19 of the CMS-1500 claim form.

Competitive Acquisition Program (CAP) for Part B Drugs

Background

This article and related Change Request (CR) 5546 provide additional details, information, and instructions for the implementation of the CAP as outlined in MLN articles 4064, 4309, 5079, 5332 and CR 4306. (The article Web addresses are listed in the *Additional Information* section of this article.)

Key Points of CR 5546

The following are the key points listed in the revised Chapter 17, Section 100 of the *Medicare Claims Processing Manual*, which is attached to CR 5546:

OLD RULES

- **Under the MMA**, payment to the approved CAP vendor for a drug **was** conditioned upon the administration of the drug to the Medicare beneficiary.
- From July 1, 2006, through March 31, 2007, proof that the drug was administered **was** established by matching the participating CAP physician's claim for drug administration with the approved CAP vendor's claim for the drug in the Medicare claims processing system by means of a prescription order number on both claims. **When the claims matched** in the claims processing system, the approved CAP **vendor was paid**.

NEW RULES

- Title 2, Section 108(a) of the Tax Relief and Health Care Act of 2006 (TRHCA), requires the Centers for Medicare & Medicaid Services (CMS) to pay an approved CAP vendor's CAP drug claim upon its receipt and to implement a **post payment review process** by April 1, 2007.
- The post payment review process is required to **assure that drugs supplied under the CAP were administered to a beneficiary**. CMS must establish a mechanism to recoup, offset or collect **any** overpayments to the approved CAP vendor. If upon post payment review, Medicare cannot substantiate drug administration, Medicare will treat that as an overpayment to the CAP vendor and take appropriate recovery action for the drug payment to the CAP vendor.
- CMS is implementing CAP claims processing changes in order to comply with TRHCA by April 1, 2007. Pending CAP claims submitted prior to April 1, 2007, but not processed by that date, and all new CAP claims submitted on or after April 1 will be paid upon receipt and will be subject to the post payment review process.

Additional Information

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

The Web links below include the complete details for this CR and MLN articles listed in the Background section of this article:

<http://www.cms.hhs.gov/Transmittals/downloads/R1207CP.pdf> for CR 5546;

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf> for article MM 4064;

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5332.pdf> for article MM 5332;

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf> for article MM 5079; and

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf> for article MM 4309.

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Palmetto Place

Dr. Hava Question



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



Here comes the List Serv Fairy to my rescue....

Want to stay informed? Just register to receive email notifications. It's EASY and it's FREE!



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

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

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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)

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

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Medicare Combined Part A & B Outpatient Therapy Seminars Coming Soon!

Do you want to hear up to the minute Medicare news on outpatient therapy services?

Would you like references and other educational materials relating to important Medicare changes? How would you like the opportunity to participate in separate break out sessions and discuss such hot topics as the UB-04 and the CMS-1500 claim forms? (Kentucky and Indiana will include professional and facility components. Illinois and Ohio will focus on the facility component.)

If you answered yes to any of these questions, please plan on joining us for an Outpatient Therapy Services Seminar!

The instructors from National Government Services presenting this important program will be on hand to answer questions about the UB-04, CMS-1500, Pulmonary Rehab, Wound Care, Documentation and much more! Representatives from Palmetto GBA will be available to assist with Part B questions.

Costs

We encourage all providers to participate in this educational opportunity at a minimal cost of \$70.00 per person. This fee includes all materials, lunch and refreshments.

Schedule and Registration

Please visit <http://www.ngsmedicare.com> to register on-line:

https://www.adminastar.com/providers/intermediary/workshops/secure/OutpatientTherapy_enroll.cfm

To fax a registration:

<http://www.adminastar.com/Providers/Intermediary/Workshops/files/FaxRegistrationNGSLetterhead2007TherapySeminars.pdf> for course description information

<http://www.adminastar.com/Providers/Intermediary/Workshops/files/CourseDescriptionNGSLetterhead2007TherapyServices.pdf>

All registration on the day of the seminar begins at 8:00 a.m.

All seminars start at 8:30 a.m. and conclude at 4:00 p.m.

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Dates and locations are listed below:

May 1, 2007

Radisson Star Plaza Hotel
800 East 81st Avenue
Merrillville, IN 46410
Phone: (219) 769-6311

May 3, 2007

Route 66 Hotel and Conference Center
625 E. Saint Joseph St.
Springfield, IL 62703
Phone: (217) 529-6626

May 8, 2007

Midwest Hotel and Conference Center
4900 Sinclair Road
I-71 and Morse Road
Columbus, OH 43229 US
Phone: (614) 846-0300

May 15, 2007

Louisville Downtown Marriot
280 West Jefferson
Louisville, KY 40202
Phone: (502) 627-5045

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Medicare Part B Small Provider Forum: Sandusky, Ohio

Palmetto GBA is sponsoring a General Medicare Part B Seminar in Sandusky, 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, May 16, 2007

Location: Holiday Inn
5513 Milan Road
Sandusky, OH 44870

Topics and Time: Medicare Updates (1:00 pm – 4:00 pm)

How to Register - The Sandusky 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!

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Registration Form: Palmetto GBA Small Provider Forums

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

Name: _____

Practice Name: _____

Practice Address: _____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

_____ Wednesday, May 16, 2007, Sandusky, 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: Sandusky, Ohio

Palmetto GBA is accepting requests for Medicare Part B One-on-One Small Provider Appointments!

Date: Thursday, May 17, 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! We will provide you with individualized education and address your specific Medicare concerns. Please be sure to submit your request for an appointment by May 11, 2007. Complete the Meeting Fax form on the following page and fax the form to 614-473-6812 along with the all topics and questions to be discussed during the appointment.

A Palmetto GBA representative will contact you by May 16, 2007, to confirm the time and location of your appointment or to make alternate arrangements.

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

When: Friday, June 8, 2007

Where: Heritage Golf Club, Hilliard

Time: 12 (Noon) - 4 p.m.

CE Credits: 4.0

Registration: <http://www.ohpsych.org>

Registration Deadline: May 30, 2007

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

Cost:

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

Meals: A boxed lunch will be provided.

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

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

Participants will learn:

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

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

Participants will learn:

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

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EDI Migration to the GPNet Front End

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

Advantages of using GPNet are:

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

Important information to know about GPNet submissions is:

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

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

Average Sales Price (ASP) Medicare Part B Drug Pricing File: April 2007 Quarterly Update

Provider Action Needed

This article is based on Change Request (CR) 5517 which informs Medicare contractors to download the April 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

For 2007, a separate fee of \$0.152 per International Unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP.

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published

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compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.
- Payment allowance limits for Influenza, Pneumococcal and Hepatitis B vaccines are 95 percent (95%) of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA)** and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent (106%) of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 19, 2007, the revised January 2007 and April 2007 ASP files and ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP Web page is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>. The revised files are applicable to claims based on dates of service as shown in the following table:

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Payment Allowance Limit Revision Date	Applicable Dates of Service
January 2007	January 1, 2007 through March 31, 2007.
April 2007	April 1, 2007 through June 30, 2007

NOTE: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code, and its associated payment limit, does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above.

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1204CP.pdf> on the CMS Web site.

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

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

Effective April 2, 2007, for services performed on or after January 1, 2007, the Centers for Medicare and Medicaid Services (CMS) has made revisions to the following HCPCS codes on the 2007 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

Claims submitted for these codes will be processed by Palmetto GBA, **not** the Durable Medical Equipment Regional Carrier, AdminaStar Federal, Inc.

HCPCS CODE		OHIO	WEST VIRGINIA
L8690	(New Purchase)	\$4,002.24	\$3,906.33
L8691	(New Purchase)	\$2,243.40	\$2,189.62

Note: Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

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Extracorporeal Photopheresis

Provider Action Needed

Impact to You

For services provided on or after December 19, 2006, coverage for extracorporeal photopheresis is now expanded to include additional health conditions.

What You Need to Know

Change Request (CR) 5464, from which this article is taken, announces (effective December 19, 2006), the expansion of coverage of extracorporeal photopheresis to include patients with acute cardiac allograft rejection and chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

What You Need to Do

Make sure that your billing staffs are aware of this expanded coverage for extracorporeal photopheresis, and bill accordingly.

Background

Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to an ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as *ex vivo* administration), but the drug can alternatively be administered directly to the patient before the white blood cells are drawn. After UVA light exposure, the treated white blood cells are then re-infused into the patient.

Formerly, Medicare covered extracorporeal photopheresis only when used in the palliative treatment of the skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy. On April 6, 2006, a request for reconsideration of this national coverage determination (NCD) to allow additional indications initiated a national coverage analysis.

CR 5464 announces the NCD resulting from that analysis. It provides that CMS has reviewed the evidence and determined that extracorporeal photopheresis is reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act for patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment, and for patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment. Effective December 19, 2006, coverage has been expanded to include these conditions.

Billing Requirements for Extracorporeal Photopheresis

You should use CPT code 36522 (Photopheresis, extracorporeal) when submitting your outpatient or physician claims for this service under these expanded coverage guidelines. Effective for dates of service on or after December 19, 2006, Medicare contractors will pay hospital inpatient, including CAH, claims

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for extracorporeal photopheresis, based on the normal payment methodology for type of bills (TOBs) 11X, 13X or 85X, according to the expanded coverage conditions. Specifically, Medicare will accept claims for extracorporeal photopheresis:

- With CPT code 36522 when submitted for the treatment of hospital outpatients and for physician services with ICD-9-CM diagnosis codes: 996.83 or 996.85; and
- With ICD-9-CM procedure code 99.88 when submitted for the treatment of hospital inpatients, including CAHs, with ICD-9-CM DX codes: 996.83 or 996.85.

Medicare contractors will not search for claims for services on or after December 19, 2006, but processed prior to the April 2, 2007, implementation date for this change. However, they will adjust such claims if you bring them to their attention.

Note: All other indications for extracorporeal photopheresis remain noncovered. Further, note that contractors will edit for an appropriate oncological and autoimmune disorder diagnosis prior to paying **according to the NCD.**

Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RAs) and Claim Adjustment Reason Code

Contractors will continue to use the appropriate existing messages that they have in place when denying claims submitted that do not meet the Medicare coverage criteria for extracorporeal photopheresis.

Contractors will deny claims when the service is not rendered to an inpatient or outpatient of a hospital, including CAHs, using the following codes:

- Claim adjustment reason code: 58 – “Claim/service denied/reduced because treatment was deemed by payer to have been rendered in an inappropriate or invalid place of service.”
 - MSN 16.2 - “This service cannot be paid when provided in this location/facility.” Spanish translation: “Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad.” (Include either MSN 36.1 or 36.2 dependant on liability.)
 - RA MA 30 - “Missing/incomplete/invalid type of bill.” (FIs and A/MACs only)
 - Group Code - CO (Contractual Obligations) or PR (Patient Responsibility) dependant on liability.

Advance Beneficiary Notice and Hospital Issued Notice of Noncoverage Information

If this service is not reasonable and necessary under 1862(a)(1)(A) of the Act (falls outside the scope of the revised NCD found in Publication 100-03, Chapter 1, Section 110.4), the physicians and/or hospital outpatient departments, including CAHs, will be held liable for charges unless the physician and/or hospital has the beneficiary sign an Advance Beneficiary Notice (ABN) in advance of providing the service.

If this service is provided to a hospital inpatient, including CAHs, for a reason unrelated to the admission (outside of the bundled payment), the hospital billing for the inpatient services will be held liable for charges

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unless the hospital has the beneficiary sign a Hospital Issued Notice of Noncoverage (HINN) letter 11 in advance of providing the service.

Note: This addition/revision of section 110.4 of the Medicare National Coverage Determinations Manual (100-03) is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Additional Information

You can find the official instruction, CR 5464, issued to your carrier, FI or A/B MAC by visiting:

<http://www.cms.hhs.gov/Transmittals/downloads/R66NCD.pdf> for the updated *Medicare National Coverage Determinations Manual* (100-03), Chapter 1, Part 2 (Sections 90-160.25) (Coverage Determinations), Section 110.4 (Extracorporeal Photopheresis); and

<http://www.cms.hhs.gov/Transmittals/downloads/R1206CP.pdf> for the updated *Medicare Claims Processing Manual* (100.04), Chapter 32 (Billing Requirements for Special Services), Section 190 (Billing Requirements for Extracorporeal Photopheresis).

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

Medical Review Frequently Asked Questions

Question: What is meant by “intensity” as it pertains to the statement that a physical or occupational therapy treatment plan must be of the appropriate type, frequency, duration, and intensity?

Answer: The intensity of a physical or occupational therapy program is determined by the patient’s individualized plan, progressing a little at a time depending on the patient’s stamina and endurance. As a patient gains strength and endurance, the therapy program will increase in intensity until the patient meets his/her individualized goals. “Appropriate intensity” means that the patient’s individualized plan should progress over time to include more strenuous exercise or wider range of motion, for example, commensurate with the patient’s treatment goal(s).

Question: When is it appropriate to submit charges for counseling of members of a patient’s family?

Answer: A physician may have contact with a patient’s family and associates for purposes other than securing background information. In some cases, the physician will provide counseling to members of the household. Family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient’s condition.

For example, two situations where family counseling services would be appropriate are as follows: (1) where there is a need to observe the patient’s interaction with family members; and/or (2) where there is a need to assess the capability of and assist the family members in aiding in the management of the patient. Counseling principally concerned with the effects of the patient’s condition on the individual being interviewed would not be reimbursable as part of the physician’s personal services to the patient. While to a limited degree, the counseling described in the second situation may be used to modify the behavior of the family members, such services nevertheless are covered because they relate primarily to the management of the patient’s problems and not to the treatment of the family member’s problems.

Resources:

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

Internet-Only Manual Publication # 100-03, Chapter 1, Section 70.1

Question: What documentation is required to submit for the Therapy Cap Exception Process in 2007?

Answer: Beginning January 1, 2007, there is no **manual process** for exceptions. Deletion of the manual process for exceptions increases the responsibility of the provider/supplier for determining and documenting that services are appropriate for use of the Automatic Process Exceptions.

The Automatic Process Exceptions 2007

An exception may be made when the patient’s condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time. The KX HCPCS modifier is added to claim lines, which indicates that the clinician attests

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that services are medically necessary and justification is documented in the medical record. **It is not necessary to submit documentation with the claims**; however, it is necessary that the medical record include justification for continued therapy beyond the Therapy Service Cap.

Resources:

- Internet-Only Manual Publication # 100-04, Chapter 5, Section 10.2
<http://www.cms.hhs.gov/manuals>
- The Medicare Claims Processing Manual transmittal: <http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf> ;
- The Medicare Benefit Policy Manual transmittal - <http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf> and
- The Medicare Program Integrity Manual transmittal - <http://www.cms.hhs.gov/transmittals/downloads/R181PI.pdf>.

Question: What are the documentation requirements for a psychotherapy treatment plan?

Answer:

The treatment plan must include at a minimum all the following:

- The patient’s relevant medical and psychiatric diagnoses; and
- The patient’s functional status; and
- The target symptoms and/or signs; and
- Long and/or short term treatment goals and objectives; and
- The patient’s prognosis; and
- The patient’s response to treatment and progress toward the goals must be indicated on all treatment plans following the initial treatment plan.

Resources:

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

- Click on “LCD Articles”, then
- “Psychiatric Therapeutic Procedures”

Initial Preventive Physical Examinations (IPPE): Reminders

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an initial preventive physical examination (IPPE), including a screening electrocardiogram (EKG) for eligible NEW beneficiaries. This is a once-a-lifetime benefit for the beneficiary.

Applicable HCPCS codes are:

G0344 - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment

G0366 - Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

G0367 - Tracing only, without interpretation and report, performed as a component of the initial preventive examination

G0368 - Interpretation and report only, performed as a component of the initial preventive examination

1. **A beneficiary is eligible when he *FIRST* enrolls in Medicare Part B and only payable if the IPPE is performed *WITHIN* the first 6 months of coverage.**
2. The IPPE examination must be performed by a doctor of medicine or osteopathy as defined in Section 1861 (R) (1) of the SSA or by a qualified non-physician practitioners (NPPS).
3. If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate HCPCS G code. The primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit. **NOTE:** Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified NPP and/or entity.
4. Refer to CMS IOM Manual, Pub 100-04, Chapter 12, and Section 30.6.1.1 for complete details for submitting these services: <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

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Colorectal Screening Services: Update to Medicare Claims Processing Manual, Publication 100-04, Chapter 18, Section 60.1

Background

The Centers for Medicare & Medicaid Services (CMS) is aware that Chapter 60, Section 60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) needed clarification regarding application of the annual Part B deductible for **diagnostic** colorectal services. Section 5113 of the Deficit Reduction Act (DRA) of 2005 **waived** the requirement for the annual Part B deductible for **screening** colorectal services, **NOT diagnostic** colorectal services. CR 5541 clarifies that portion of the manual.

Key Points

The following are the key points of the revised portion of Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual*, which is attached to CR 5541 (the Web address for CR 5541 is provided in the *Additional Information* section of this article).

Prior to January 1, 2007, deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120, and G0121. **On or after January 1, 2007**, the annual Part B deductible is waived for the listed HCPCS coded **screening services**. **Coinsurance still applies**.

Coinsurance and deductible applies to the diagnostic colorectal service CPT codes 45330, 45378, and 74280.

Additional Information

You may see the official instruction (CR 5541) issued to your Medicare carrier, FI, or A/B MAC by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1217CP.pdf> on the CMS Web site.

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

Chronic Renal Disease Repetitive Ambulance Transports: Common Errors and Claim Submission Tips

Palmetto GBA implemented a new process for handling claims for “chronic renal disease” repetitive ambulance transports in January 2006. Following is a summary of the most common errors we have seen on these claims during the past year and tips for submitting claims accurately the first time.

Parent Claims

A “parent claim” is the first claim to define a coverage period. When this process begins, the first claim for each beneficiary will be a parent claim. Submit parent claims with supporting documentation. We **strongly recommend** that you **not** submit subsequent claims until you receive your faxed coverage decision for the parent claim (you should receive this fax within 1-2 business days after submitting your electronic claim). Submitting additional subsequent claims before you have received the parent claim coverage decision will result in additional requests for documentation and delays in reimbursement.

The most frequent errors made by providers when submitting parent claims include:

- No Physician Certification Statement (PCS) is submitted with the documentation.
- PCS is signed by someone other than a physician.
- The PCS was signed more than 60 days before the date of the transport.
- The date is typed or stamped on the PCS next to the physician signature. It must be written at the time the PCS is signed.
- The PCS is signed, but no other information is provided to establish the medical necessity for the trip.
- Conflicting documentation is submitted (e.g., the PCS and the run sheet present different information about the patient’s condition at the time of transport).

Claims that are submitted with insufficient or conflicting documentation will be denied. These claims may be appealed through the Redetermination process. You may submit the next claim for ambulance transportation for that beneficiary as a new “parent claim,” and be sure to submit supporting documentation with this claim.

Other Common Errors

- Multiple claims for a patient are submitted at the same time, or subsequent claims are submitted before Palmetto GBA has made a coverage decision on the parent claim. In these situations, Palmetto GBA sends a separate written request for supporting documentation for **each** claim.
- Supporting documentation is not sent in response to written requests from Palmetto GBA. If you do not respond to these requests, Palmetto GBA denies the claims in question.
 - If you have claims that are constantly being denied, for documentation not received in a timely manner, please call the Provider Contact Center at 877-567-9232 to verify that your mailing/billing address on file is correct.

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- Submit an updated CMS-855 form to notify Palmetto GBA of any changes in your mailing or billing address. For assistance in completing this form, contact the Provider Enrollment Support Line at 1-866-308-5439.

Palmetto GBA Statistics: October 2005 - February 2007

From October 2005 through February 2007:

- Total number of beneficiaries for which coverage decisions are on file - **2,340**
- Total number of beneficiaries with “indefinite status” (a coverage decision that lasts indefinitely) - **1,399 (60%)**

From October 2006 through February 2007:

- Total number of claims for CRD ambulance transportation paid - **2,497**
- Total number of denied claims for CRD ambulance transportation - **1,052** (please see the “Other Common Errors” section for tips on preventing denials)
- Palmetto GBA is generally able to make coverage decisions on parent claims within two business days.

Other Requests for Documentation

You may be notified of a prepayment or postpayment review. If this occurs, please be aware that you are required to submit documentation if requested, regardless of whether the services fall into an approved coverage period. These audits are a result of analysis of data, such as:

- Cost per beneficiary in relation to your peers
- Dollars paid to supplier of service
- Number of services provided to a beneficiary

When responding to these requests, please be sure to include all documentation that addresses the medical necessity of the transport, as well as a complete and current, physician signed and dated PCS.

Resources

- Palmetto GBA Web site:
 - December 2005 *Medicare Advisory*: complete instructions about submitting claims to Palmetto GBA for chronic renal disease ambulance transports.
 - Ambulance articles
 - Ohio providers: <http://www.PalmettoGBA.com/boh/articles>
 - West Virginia providers: <http://www.PalmettoGBA.com/bwv/articles>
 - CMS Web site:
 - Medicare Benefit Policy, Chapter 10, Ambulance: http://www.cms.hhs.gov/manuals/102_policy/bp102c.pdf
 - Medicare Claims Processing, Chapter 15, Ambulance: http://www.cms.hhs.gov/manuals/104_claims/clm104c15.pdf
 - Code of Federal Regulations: <http://www.gpoaccess.gov/cfr/index.html>
 - § 410.40 Coverage of Ambulance Services
 - § 410.41 Requirements for Ambulance Suppliers

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Ambulance Fee Schedule/Ground Ambulance Services: Revision to the Specialty Care Transport (SCT) Definition

Provider Action Needed

Providers and suppliers are reminded that the Centers for Medicare & Medicaid Services (CMS) expanded the interpretation of “interfacility” to include both hospitals and skilled nursing facilities (SNFs) in the December 1, 2006 (71 FR 69716) final rule.

Background

In the February 27, 2002, *Federal Register* (67 FR 9100) a final rule was published with comment period entitled “*Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services*” that implemented the ambulance fee schedule. In that rule, CMS defined SCT at Section 414.605. In the December 1, 2006 (71 FR 69716) final rule, CMS expanded the definition of “interfacility” to include both hospitals and skilled nursing facilities (SNFs).

In addition, CMS further clarified the kinds of facilities included as origin or destination points for “interfacility” transport for Specialty Care Transport (SCT) purposes. Therefore, for purposes of SCT payment, CMS considers a “facility” to include:

- Only a SNF or a hospital that participates in the Medicare program, or
- A hospital-based facility that meets the requirements for provider-based status.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children’s hospitals, psychiatric hospitals, Critical Access Hospitals (CAHs), inpatient acute-care hospitals, and Sole Community Hospitals (SCHs).

Note: Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

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 (CR5533) issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R68BP.pdf> on the CMS Web site.

Providers may review the Federal Regulations for the Ambulance Fee Schedule located at http://www.cms.hhs.gov/AmbulanceFeeSchedule/04_CFRAFS.asp#TopOfPage.

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Ventricular Assist Devices (VADs)

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5516 which announces that, effective March 27, 2007, new facility criteria are established and hospitals must receive certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under their Disease Specific Certification Program for Ventricular Assist Devices (VADs). The new criteria apply to hospitals that implant VADs for the destination therapy indication.

What You Need to Know

Currently approved hospitals will have until March 27, 2009, to become certified by the JCAHO or they will be removed from the approved list.

What You Need to Do

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

Background

A VAD is an implantable device used to assist a damaged or weakened heart in pumping blood. These devices are used for support of blood circulation 1) post-cardiotomy, 2) as a bridge to a heart transplant, or 3) as destination therapy. Destination therapy is defined as use of a device as the end result of treatment (i.e., permanent transplantation), instead of a “bridge” to transplantation. Destination therapy is an indication for patients that are not heart transplant eligible, and therefore, they expect to require use of the VAD through the end of life.

Through a National Coverage Determination (NCD) Manual (Publication 100-03), Section 20.9, “Artificial Hearts and Related Devices”) issued on October 14, 2003 (CR 2958, Transmittal 2; <http://www.cms.hhs.gov/Transmittals/Downloads/R2NCD.pdf>), Medicare began coverage of the destination therapy indication. The 2003 decision established hospital criteria and an application process through which hospitals were required to submit information to the Centers for Medicare & Medicaid Services (CMS). If approved, the hospital(s) were listed as an approved VAD destination therapy hospital on the CMS Web site at (<http://www.cms.hhs.gov/MedicareApprovedFacilitie/VAD/list.asp#TopOfPage>). At that time, Medicare contractors were instructed to use this VAD Destination Therapy Facilities Web site to determine which hospitals in their area were Medicare approved for VADs as destination therapy.

CR 5516 announces that, effective March 27, 2007, new facility criteria are established. Included in the facility criteria are requirements that:

- Facilities must have at least one member of the VAD team with experience implanting at least 10 VADs (as bridge to transplant or destination therapy) or artificial hearts over the course of the previous 36 months;

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- Facilities must be a member of the Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS); and
- By March 27, 2009, all facilities must meet the updated CMS facility criteria and be credentialed by the JCAHO under their Disease Specific Certification Program for VADs (standards dated February 2007).

The VAD Destination Therapy Facilities Web site will be continuously updated by CMS to maintain a current list of approved facilities. Medicare contractors will continue to use this Web site to determine which hospitals are covered by Medicare when VADs are implanted as destination therapy.

Additional Information

The official instruction, CR 5516, issued to your carrier, intermediary, or A/B MAC regarding this change may be viewed on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R68NCD.pdf>.

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

Radiology and Pathology Laboratory Services: Technical Component Provided to Hospital Patients & Common Working File (CWF) Duplicate Claim Edits

Note: This article was revised on April 20, 2007, to show that important new information on this issue is available in *MLN Matters* article MM 5468 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5468.pdf>). In essence, according to MM 5468, qualifying independent laboratories may continue to bill Medicare for the TC of physician pathology services furnished to Medicare patients of a covered hospital stay during calendar year 2007. Be sure to view MM 5468 for details.

Provider Types Affected

Radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and non-physician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Background

Current Medicare billing practices allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the Prospective Payment System (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007 for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

Key Points

Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and

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discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.

Effective for claims received on or after April 1, 2007, Medicare will reject/deny reject a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13X and 85X0 previously processed by Medicare).

If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use Remittance Advice Reason Code 109 "Claim not covered by this payer/contractor." when denying a service line item.

Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same Remittance Advice Reason Code of 109 will be used in such cases.

Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use Remittance Advice Reason Code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.

Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

Additional Information

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

For complete details regarding this CR, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1221CP.pdf>.

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Erythropoiesis-Stimulating Agents (ESA) Alert

As a result of the studies on Erythropoiesis-Stimulating Agents (ESA), the Food and Drug Administration (FDA) issued an alert on 11/16/06 with updates on 02/16/07 and 03/09/07. Since the FDA has determined that all ESA have the same action, the warning and subsequent product labeling change effect Aranesp® (darbepoetin alfa), Epogen® (epoetin alfa) and Procrit® (epoetin alfa).

The new box warning on the product labeling includes the following information:

- Prescribe the lowest ESA dose that will gradually increase the hemoglobin concentration to the lowest level sufficient to avoid blood transfusions.
- Consider ESA increased death risk for serious cardiovascular events when patients were dosed to achieve hemoglobin targets > 12g/dL.
- Consider patients preoperatively treated with ESA had a higher incidence of deep vein thrombosis. However, the test cases did NOT receive anticoagulant therapy. Unapproved indication for Aranesp.

For cancer patients treated to achieve > 12g/dL, the package insert provides the following warning:

- ESA shortened the time to tumor progression in patients with advanced head and neck disease receiving radiation.
- ESA shortened overall survival and increased deaths attributed to disease progression in patients with metastatic breast cancer receiving chemotherapy.
- ESA increased the risk of death in patients with active malignant disease not under chemotherapy or radiation treatment. ESA are not indicated for this population.

According to Palmetto GBA's active policy, Erythropoiesis Stimulating Proteins for Patients Not on Dialysis, LCD# L5968, ESA is not covered for the following conditions:

- To increase the amount of blood that can be drawn for auto-donation
- To treat blood loss in patients who refuse transfusions for religious or other reasons
- For pre-operative priming of a patient (without documented anemia prior to surgery) in anticipation of post-operative anemia
- To treat anemia of chronic disease except for the specific pre-operative use and myelodysplasia described in the policy
- To treat anemia associated with malignancy related to the disease itself rather than concomitant chemotherapy
- To treat anemia secondary to radiation therapy

NOTE: Based on the FDA's alert and the subsequent product labeling changes, Palmetto GBA will review the active policy and as approved by CMS may implement future additional changes without the usual notice and comment period.

References:

FDA site: <http://www.fda.gov/cder/drug/InfoSheets/HCP/RHE2007HCP.htm>

Policy: <http://www.PalmettoGBA.com/boh> (Ohio) or <http://www.PalmettoGBA.com/bwv> (West Virginia) and select Medical Policies

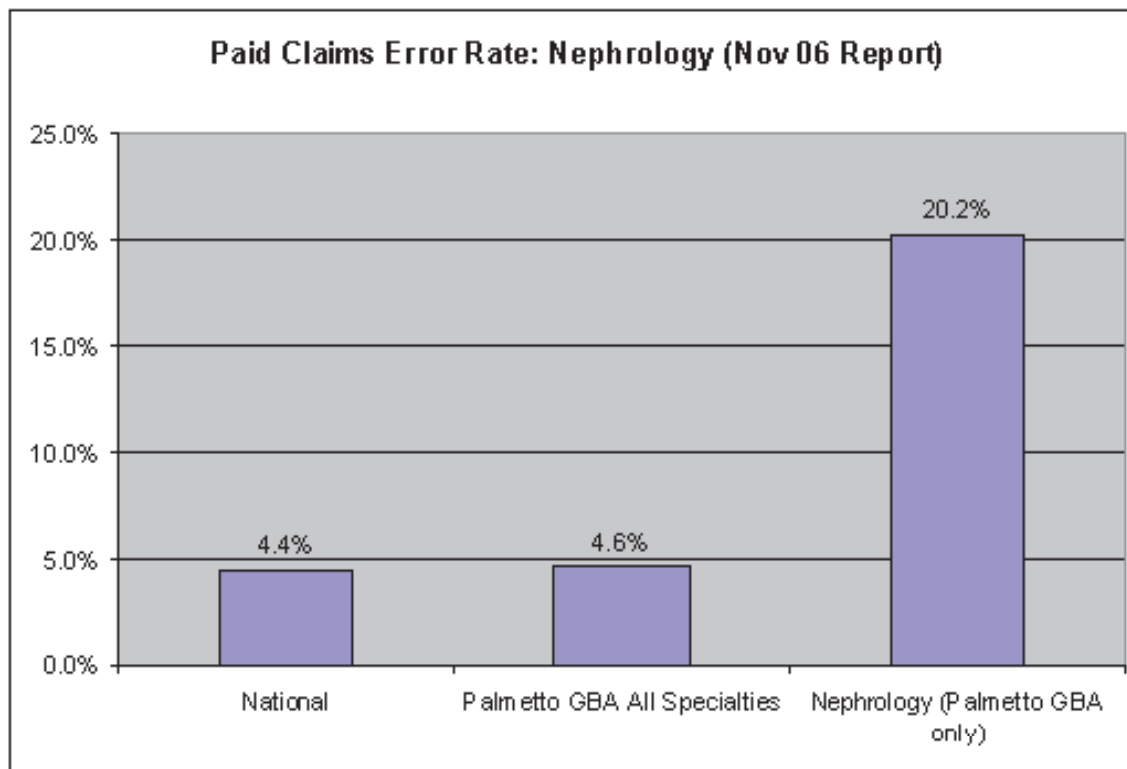
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Nephrology: Documentation and Claim Submission

The latest results from the Comprehensive Error Rate Testing (CERT) program have arrived. Through the CERT program, accuracy measures for claims submitted to Palmetto GBA and payments that we make are received. We analyze these measures by reviewing national, carrier and specialty specific results. These results are the primary data sources Palmetto GBA uses to assess the effectiveness of our education.

In the November 2006 CERT report, there are several outcomes specifically related to procedures performed by nephrologists (specialty 39 physicians). This report includes claims submitted from April 2005-March 2006.

- ***Nephrologists have the highest Paid Claims Error Rate and Provider Compliance Error Rate among all Palmetto GBA provider specialty types.***

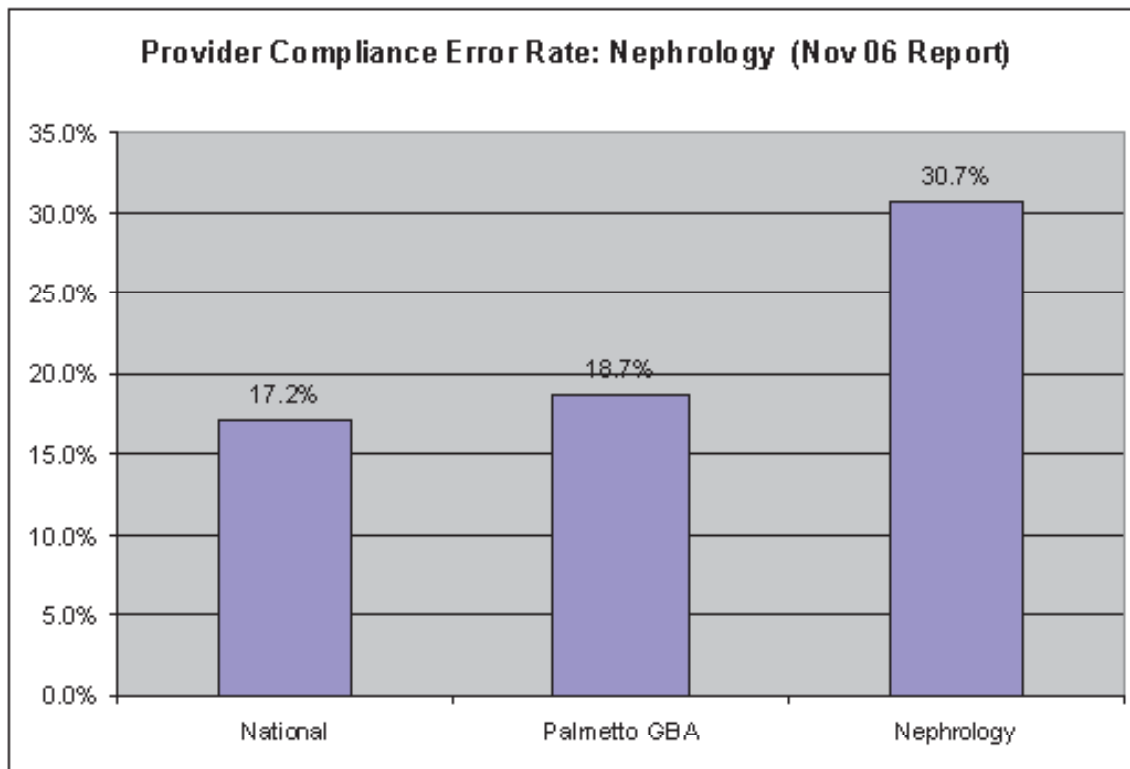


- The **Paid Claims Error Rate** is a measure of the percentage of incorrect payments. The percentage of incorrect payments in the sampled claims is projected across the entire universe of payments for the identified code grouping. Among paid claims errors assessed during this period:
 - The code group with the highest paid claims error rate is Evaluation and Management (E/M) codes.
 - Among claims included in the sample from nephrologists, E/M codes account the majority of errors.

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- The **Provider Compliance Error Rate** is a measure of the accuracy of submitted claims. Sampled claims are compared to supporting documentation. The accuracy measure in the sampled claims is applied to the universe of claims submitted by nephrologists. Factors that influence the accuracy of submitted claims include:
 - Duplicate claims (submitting a claim to Palmetto GBA that has already been processed and reimbursed)
 - Selection of CPT or HCPCS codes versus documentation in the medical record
 - Correctly selecting services that are *included in* and *excluded from* Monthly Capitation Payments (MCP)
 - Documentation of the number of visits in the month
 - Accurate reporting of ICD-9-CM codes
 - Correct submission of and documentation for all modifiers

Documenting and Submitting E/M Services

- We strongly encourage all providers and their staff members to become familiar with the E/M Documentation Guidelines, which were developed jointly by CMS and the American Medical Association.
- Take advantage of free training offered by Palmetto GBA clinical education staff to learn more about how to understand and apply the E/M Documentation Guidelines. To view a list of upcoming workshops

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in Ohio, go to <http://www.PalmettoGBA.com/boh/education>. For West Virginia workshops, refer to <http://www.PalmettoGBA.com/bwv/education>.

- Conduct internal audits of documentation vs. code selections, especially for E/M services.
- Consider using a standardized “scoring tool” for consistency in applying the E/M Documentation Guidelines. Palmetto GBA publishes one such tool on our Web site, although there are many others from which to choose.

Preventing Errors: Resources for Nephrology Practices

What is it?	Where can you find it?
<p>Palmetto GBA <i>Modifier Lookup</i></p>	<p>Find guidance on documenting and submitting CPT and HCPCS modifiers correctly.</p> <p>Ohio providers: http://www.PalmettoGBA.com/boh/articles (select Modifier Lookup)</p> <p>West Virginia providers: http://www.PalmettoGBA.com/boh/articles (select Modifier Lookup)</p>
<p>The Palmetto GBA <i>End Stage Renal Disease (ESRD) Educational Packet:</i> a comprehensive review of all CMS and Palmetto GBA guidelines related to ESRD</p>	<p>Ohio providers: http://www.PalmettoGBA.com/boh/articles (select ESRD)</p> <p>West Virginia providers: http://www.PalmettoGBA.com/bwv/articles (select ESRD)</p>
<p>The Palmetto GBA <i>Physician/Supplier Guide:</i> a reference guide for CRD and ESRD Medicare guidelines</p>	<p>Ohio providers: http://www.PalmettoGBA.com/boh/guide</p> <p>West Virginia providers: http://www.PalmettoGBA.com/bwv/guide</p>
<p>Palmetto GBA: <i>Evaluation and Management Documentation Guidelines Educational Packet</i></p> <p><i>Hospital Evaluation & Management Services Educational Packet</i></p> <p><i>E/M “Score Sheet”</i></p>	<p>Ohio providers: http://www.PalmettoGBA.com/boh/education</p> <p>West Virginia providers: http://www.PalmettoGBA.com/bwv/education</p>

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What is it?	Where can you find it?
Palmetto GBA: <i>E/M FAQs</i>	Ohio providers: http://www.PalmettoGBA.com/boh/resources (select FAQs, Medical Review) West Virginia providers: http://www.PalmettoGBA.com/bwv/resources (select FAQs, Medical Review)
CMS: <i>Physician’s Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services</i>	http://www.cms.hhs.gov/MLNProducts/downloads/Book_Kidney_Dialysis-Final.pdf
CMS: Instructions to Medicare Contractors (Internet Only Manuals)	http://www.cms.hhs.gov/manuals/IOM/list.asp <ul style="list-style-type: none"> • Pub. 100-02, chapter 11: End Stage Renal Disease • Pub. 100-04, chapter 8: Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims • Pub. 100-04, chapter 16: Laboratory Services

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Chemotherapy & Biologicals

Effective Date: May 1, 2007

Billing the Days/Units Fields for Drugs and Biologicals:

- Drugs are billed in multiples of the dosage specified in the HCPCS/NDC. If the dosage given is not a multiple of the Health Insurance Common Procedure Coding System (HCPCS) code, the provider rounds to the next highest units in the HCPCS description for the code.
- If the full dosage provided is less than the dosage for the code specifying the minimum dosage for the drug, the provider reports the code for the minimum dosage amount.

Not Otherwise Classified (NOC) Drugs:

- When claims are submitted for HCPCS codes J9999 (not otherwise classified anti-neoplastic drugs), J3490 (unclassified drugs), and J3590 (unclassified biological drugs), the drug name, the National Drug Code (NDC) number and total dosage must be indicated in the narrative field of the CMS-1500 claim form. The correct number of units for submitting a not otherwise classified (NOC) code is always "1" one. The reimbursement will be based on the dosage indicated in the narrative field.

Discarded Drugs:

- Discarded portions – CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered. When submitting a claim for situations when a portion of the drug supplied is unused (discarded), include the total of both the unused and the used portion in the days/units field when reporting the dosage.
- The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drugs.

Intravenous Fluids:

- Intravenous fluid administration when administration of a chemotherapeutic agent does not require it to be administered by infusion in a volume of 250 cc or greater (i.e., HCPCS codes J7030-J7050, J7060, J7070, J7120) will be denied.
- Intravenous fluids used to maintain venous patency during administration of chemotherapeutic agents are considered integral to chemotherapy and is not separately billable.
- Flushing of a vascular access device will be denied if submitted on a claim on the same date of service as the administration of chemotherapy.

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Off-Label Cancer Chemotherapy Use:

- Use HCPCS code J9999. Use HCPCS code J9999 even though the drug may have an assigned HCPCS code.
- Indicate OFF-LABEL CHEMO DRUG - SPECIAL CONSIDERATION in the narrative field of the CMS-1500 claim form.
- The name of the drug, the NDC number and dosage must also be in the narrative field of the CMS-1500 claim form.
- Submit required documentation as listed in CMS Benefit Policy Manual, Chapter 15, and Section 50.4.5 should be submitted with the initial claim.

If the initial claim was submitted with the above guidelines, subsequent claims for the same patient for off-label cancer chemotherapy use may now be submitted with the following guidelines:

- Use HCPCS code J9999.
- Indicate OFF-LABEL CHEMO DRUG - SPECIAL CONSIDERATION in the narrative field of the CMS-1500 claim form.
- The name of the drug, the NDC number and dosage must also be in the narrative field of the CMS-1500 claim form.
- Subsequent claims for the same patient will not need the additional documentation for off-label use to be submitted once the initial claim has been paid.

Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors

What Providers Need to Know

Effective for claims with dates of service on or after March 20, 2007, the use of osmotic blood brain barrier disruption is not considered reasonable and necessary when it is used as part of a treatment regimen for brain tumors in Medicare patients.

Background

This article and Change Request (CR) 5530 states that Medicare does not currently have a national coverage determination (NCD) for osmotic blood brain barrier disruption (BBBD) as part of a treatment regimen for brain tumors. The Centers for Medicare & Medicaid Services (CMS) accepted a formal request for **non-coverage** of BBBD used for this indication.

CMS determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors.

Be aware that the BBBD process includes all items and services necessary to perform the procedure, including hospitalization, monitoring, and repeated imaging procedures.

This NCD does not alter in any manner the coverage of anti-cancer chemotherapy.

Additional Information

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

CR 5530 is the official instruction issued to your Medicare FI, Carrier or MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R67NCD.pdf> on the CMS Web site.

Transpupillary Thermotherapy (TTT)

According to Palmetto GBA's review of current evidence-based literature and, as confirmed by the American Academy of Ophthalmology, the efficacy and safety of transpupillary thermotherapy (TTT) has ONLY been established for treatment of small choroidal melanomas (Category III CPT code 0016T). The safety and efficacy for treating Age-related Macular Degeneration (AMD) with TTT has NOT been established. Therefore, effective May 1, 2007, Palmetto GBA will only reimburse TTT services for the treatment of small choroidal melanomas.

- CPT code 0016T - Destruction of localized lesion of choroid (eg, choroidal neovascularization), transpupillary thermotherapy.
- ICD-9 code 190.6 - Malignant neoplasm of eye - choroid.

Psychiatric Services: Reminder

When submitting claims for psychiatric services, please refer to the following information to assist in the determination of coverage and correct coding procedures.

Independent Clinical Psychologists, Independent Psychologists, and Independent Social Workers

Definition: He/she renders services on his/her own responsibility, free of the administration and professional control of an employer such as a physician, institution, or agency; he/she treats his/her own patients; and he/she has the right to submit claims directly, collect and retains fees for services rendered.

A clinical psychologist, psychologist or social worker practicing in an office located in an institution may be considered an independent practicing provider if both of the following are met:

1. The office must be confined to a separately identified part of the facility which is used solely as the psychologist's/social worker's office and cannot be construed as extending throughout the entire facility; and
2. He/she carries on a private practice (i.e., services are rendered to patients from outside the facility as well as to institutional patients).

Physician (Usually, but not limited to a Psychiatrist)

Specialty:	26
Billable Service(s):	Diagnostic and therapeutic services.
Claims Assignment:	Claims may be assigned or non-assigned – depending upon the participating/non-participating agreement.

Psychologist (Billing Independently)

Specialty:	62
Definition of Provider:	Holds a Master's Degree in psychology. May hold a Ph.D., but doesn't meet other criteria for clinical psychologist designation. Meets licensing or certification standards required by the state.
Billable Service(s):	Diagnostic Services CPT Codes 96101-96155
Claims Assignment:	Claims may be assigned or non-assigned.

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Clinical Psychologist

Specialty:	68
Definition of Provider:	Holds a Ph.D. in psychology. Meets licensing or certification standards required by the state.
Billable Service(s):	Diagnostic and Therapeutic Services CPT Codes: 90801-90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90846-90849, 90853-90857, 90875-90876, 90880, 90899, 96101-96155
Claims Assignment:	Must accept assignment.

Licensed Independent Social Worker (LISW) – Ohio Licensed Certified Social Worker (LCSW) – West Virginia

Specialty:	80
Definition of Provider:	Holds a Master’s Degree or Ph.D. in social work. Licensed by the state as LISW or LCSW.
Billable Services:	Therapeutic Services CPT Codes: 90801-90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90846-90849, 90853-90857, 90875-90876, 90899, 96101-96155
Claims Assignment:	Must accept assignment.

Non-Physician Practitioners Physician Assistant (PA), Nurse Practitioner (NP) Clinical Nurse Specialist (CNS)

Specialty:	97 – PA 50 – NP 89 – CNS
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Definition of Provider:	<p>PA: Be licensed by the state to practice as a physician’s assistant.</p> <p>NP: Be a registered nurse (R.N.) who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with the law.</p> <ul style="list-style-type: none"> • Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. • Possess a Master’s Degree in Nursing. <p>CNS: Be a registered nurse (R.N.) who is currently licensed to practice in the state where he/she practices and authorized to furnish the services of a clinical nurse specialist in accordance with the state law.</p> <ul style="list-style-type: none"> • Have a Master’s Degree in a defined clinical area of nursing from an accredited educational institution; and be certified as a clinical nurse specialist by the American Nurses Credentialing Center.
Billable Services:	<p>CPT Codes: 90801, 90804-90829, 90845-90849, 90853-90857, 90862, 90887, 96101-96155</p>
Claims Assignment:	<p>Must accept assignment.</p>

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Fraud and Abuse and the Role of the Program Safeguard Contractor

Millions of beneficiaries depend on the Medicare program to provide reimbursement for medical care they receive. The Medicare program also provides tens of thousands of providers and suppliers of services payment for the services they provide. The Medicare program is both complex and carries a huge responsibility to ensure that federal dollars are spent within the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) and the Social Security Act. Because of the sheer size and nature of this government program, there, unfortunately, exist opportunities for fraud, waste and abuse of federal health care dollars.

The Program Safeguard Contractor's (PSC) job is to protect the Medicare Trust Fund from activities that are wasteful, fraudulent or abusive to the program. The efforts of the PSC are to work within a collaborative framework of organizations such as the Office of Inspector General, the Federal Bureau of Investigation, the Department of Justice, the Medicaid Fraud Control Units, the Affiliated Contractors, the Quality Improvement Organizations, the Department of Health and Human Services and many other state agencies to get the job done. Many Medicare stakeholders ask the question, "How much money are we actually spending on recovery of fraudulent Medicare payments and what is the return?" A group of individuals called the Taxpayers against Fraud and Abuse just completed a study that concluded that for every dollar spent by CMS to recoup dollars spent on fraud and abuse activities, \$15.00 are recovered.

The PSC uses a variety of tools including data analysis, fraud complaints, medical review, investigation and referrals to perform their benefit integrity work. They also develop innovative tools and techniques to identify potential Medicare fraud and abuse. These approaches are used in building and referring cases to law enforcement for further investigation of those who are suspected of perpetrating Medicare fraud. The rules that the PSC must comply with are clearly spelled out in the Program Integrity Manual, which is available for review on the CMS Web site.

Fraud is defined as an intentional deception or misrepresentation that an individual or entity makes, knowing it to be false, that could result in an unauthorized benefit to them. The key to understanding how fraud differs from abuse is in the word intentional, for example:

"I know I am doing something wrong (intentional), I take steps to cover it up (deception) and I accept money that I am not entitled to (unauthorized benefit)."

Abuse describes incidents or practices of providers, physicians or suppliers, or services and equipment which, although not usually fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the program, improper payment or payment for services which fail to meet professionally recognized standards of care or which are not medically unnecessary.

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If you suspect such practices, you should contact AdvanceMed at (614)-801-2310 and ask for David Roden, Benefit Integrity Manager. It is the job of every citizen to report suspected fraud and abuse activities, so the Medicare program can continue to thrive in the future to service our nation's beneficiaries with their future health care needs.

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

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

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

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

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

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

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Local Coverage Determination Updates: May 2007

LCD	Change	Effective Date
Radiation Oncology Services draft 2000-03LR19	Revised policy posted for comment & notice on 04/11/07. Addition to policy of CPT code 0073T (compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution compensator convergent beam modulated fields, per treatment session). Added under <i>Indications and Limitations</i> section the definition of High-dose rate (HDR) Brachytherapy (CPT codes 77781 – 77784)	08/01/07
Paravertebral Facet Joint Block draft 2000-31LR7	Revised policy posted for comment & notice on 04/11/07. Frequency limitations added under <i>Utilization Guidelines</i> for therapeutic blocks. Current frequency limitations moved from <i>Indications and Limitations</i> section to <i>Utilization Guideline</i> section.	08/01/07
Skin Substitutes for Wound Healing draft 2005-07LR2	Revised policy posted for comment & notice on 04/11/07. Language added to <i>Indications and Limitations</i> section indicating non-coverage for any wound treatment that does not meet the definition of either HCPCS code J7340 (dermal and epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter) or J7342 Dermal (substitute) tissue of human origin, with or without other bio-engineered or processed elements, with metabolically active elements, per square centimeter.	08/01/07
Non-Covered Category III CPT codes draft 2007-01L	New Policy Developed to clarify local coverage determinations for specific Category III CPT codes.	8/01/07



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

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

General Information

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

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

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

Date of initial determination: _____ Provider Phone Number: _____

*Date of Service: _____ Who are you:

*CPT code(s): _____ Provider

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

Billed Charge: _____ Patient with Medicare

Patient's Representative

Other

This is an appeal for:

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

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

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

Reason for request: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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

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Reconsideration Request Form - QIC 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

Palmetto GBA – West Virginia Medicare Part B Carrier (Carrier 00884)
Post Office Box 182934 • Columbus, Ohio • 43218-2934
Beneficiary Service Center: (800) MEDICARE • Provider Service Center: (877) 567-9232
A CMS Contracted Intermediary and Carrier

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Call Center

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

TTY 1-877-391-9739

Provider Enrollment Support Line

1-866-308-5439

Electronic Data Interchange (EDI) Technical Support

1-866-308-5438

Medicare Secondary Payer

1-866-308-5442

Telephone Reopenings

1-866-308-5441

Medicare Fraud Hotline

1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

<http://www.PalmettoGBA.com>

Important Sources For You

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

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

Attention: Billing Manager

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Columbus, Ohio
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