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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2008, Issue 5

www.cms.hhs.gov

www.PalmettoGBA.com

May 2008

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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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**Notice of New Interest Rate for Medicare
Overpayments & Underpayments:
3rd Update for FY 2008**

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (five percent for calendar year 2008) 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 **11.375 percent** effective **April 18, 2008**.

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Web Site for Additions/Deletions of ZIP Codes Requiring a Plus Four ZIP Code Extension

Provider Types Affected

Physicians, providers, and other health care providers submitting anesthesia claims to paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

Impact to You

The ZIP code where services are rendered determines the payment locality for services paid under the MPFS and for anesthesia services. Certain ZIP codes fall into more than one payment locality and require a plus four ZIP code extension to ensure proper payment. (See the MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site for further details about ZIP code reporting.)

What You Need to Know

The CMS will begin posting additions and deletions to the list of ZIP codes that require a plus four ZIP code extension on their website. A complete list of all ZIP codes requiring a plus four ZIP code extension will also be posted.

What You Need to Do

Make certain your billing staffs are aware of these resources for checking plus four ZIP code extension requirements.

Key Points of CR 5970

- To access a file containing the quarterly additions and deletions to the list of ZIP Codes requiring a plus four extension refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp. The file is named “ZIP Code Changes” and can be found in the Downloads section of this Web page.
- To access a file containing all ZIP Codes requiring a plus four extension, refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp. The file is named “ZIP Codes Requiring +4 Ext” and can be found in the Downloads section of this Web page.
- Upon release of a new quarterly update, the previous quarter’s additions and deletions are incorporated into the file name “ZIP Codes Requiring +4 Ext” file and are not included in the “ZIP Code Changes” file.

Additional Information

To see the official instruction (CR 5970) issued to your Medicare FI, carrier, A/B MAC or RHHI refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1480CP.pdf>.

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

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Jurisdiction for Equipment, Supplies, Orthotics and Prosthetics: Which Contractor Processes the Claim?

- The CMS Web site contains a jurisdiction spreadsheet by procedure code. Currently, the most recent jurisdiction list available is for calendar year 2006. The jurisdiction spreadsheet is available on the CMS Durable Medical Equipment (DME) Web page: <http://www.cms.hhs.gov/center/dme.asp>
 - Generally, claims for DME, prosthetics, orthotics, and supplies are submitted to the DME Medicare Administrative Contractor (DME MAC) **unless** the device or item is implanted. Claims for implanted DME must be submitted to Palmetto GBA.
- The January 2008 *Coding and Reimbursement Update* contains:
 - Payment amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including splints and casts
 - A list of splint and cast codes that are “carrier jurisdiction” (submitted to Palmetto GBA)

Joint Jurisdiction

These codes have “joint jurisdiction,” meaning that they may be submitted to Palmetto GBA or to National Government Services (the DME MAC for beneficiaries residing in Ohio) or CIGNA (the DME MAC for beneficiaries residing in West Virginia), depending on certain criteria.

HCPCS Code	Description	Submit to Palmetto GBA, IF:
A4310-A4359	Incontinence supplies/ urinary supplies	Provided in the physician’s office for a temporary condition
A4361-A4434	Ostomy supplies	Provided in the physician’s office for a temporary condition
A5051-A5093 and A5102-A5200	Additional ostomy supplies	Provided in the physician’s office for a temporary condition
A9900	Miscellaneous DME supply or accessory	Used with implanted DME
A9999	Delivery	Used with implanted DME
E0781	Ambulatory infusion pump	The infusion is initiated in the physician’s office, and the patient does return during the same business day
E1340	Repair or non-routine service	Used with implanted DME
E1399	Miscellaneous DME	Used with implanted DME

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HCPCS Code	Description	Submit to Palmetto GBA, IF:
L7500-L7520	Repair of prosthetic device	Repair of implanted prosthetic device
L8499	Unlisted procedure for miscellaneous prosthetic service	Repair of implanted prosthetic device
L9900	Miscellaneous orthotic or prosthetic component or accessory	Repair of implanted prosthetic device

These supplies are considered carrier jurisdiction; however, they are **not** payable by Palmetto GBA if they are provided “incident to” a physician’s service (do not submit these to NGS or CIGNA):

HCPCS Code(s)	Description
A4206-A4209	Medical, surgical, and self-administered injection supplies
A4211	
A4213-A4215	
A4221-A4250	
A4265	Paraffin
A4305-A4306	Disposable drug delivery system
A4450-A4455	Tape; adhesive remover
A4462	Abdominal dressing
A4481	Tracheostomy supply
A4556-A4558	Electrodes; lead wires; conductive paste
A4595	TENS supplies
A4614	Peak flow rate meter
A4615-A4629	Oxygen and tracheostomy supplies
A4649	Miscellaneous surgical supplies
A6010-A6024	Surgical dressing
A6154-A6411	Surgical dressing (except if supply is for implanted prosthetic device or implanted DME – in this case, submit to Palmetto GBA)

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Other Tips

- Injections that are administered “incident to” a physician’s service are submitted to Palmetto GBA.
- Contact lenses and glasses are submitted to the DME MAC (NGS for Ohio, or CIGNA for West Virginia).
- Generally, if the item or service is related to an implanted prosthetic device or DME, claims are submitted to Palmetto GBA.
- If you submit a claim to the wrong carrier, the claim will be rejected as a billing error (remark code MA130).
- Claims for DME, prosthetics, orthotics, and supplies all require the name and NPI of the referring/ordering provider, *even if* this provider is the same provider who is submitting the claim. When these services are submitted without the referring/ordering provider’s name and NPI, they will be rejected (remark code MA130) and must be resubmitted on a new claim with this information.

Are Your Medicare Secondary Claims Rejecting?

Medicare Secondary Payer (MSP) refers to instances in which Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. This is because the Medicare beneficiary may be entitled to other coverage, which should pay the primary health benefits.

MEDICARE SECONDARY CLAIMS CAN BE SUBMITTED ELECTRONICALLY; however, Palmetto GBA has been forced to reject numerous claims because there was a mismatch between the MSP Type submitted on the claim and the specific patient's Medicare record. Below are some examples of situations that you may wish to verify when you receive these Medicare rejections:

- Do all of your claims contain the same MSP Type (example: MSP type 47) when Medicare does not show this to be a valid MSP type for the specific patient?
- If you submit your claims to a clearinghouse, does your clearinghouse understand that claims involving MSP require that a correct MSP Type be submitted with the claim?
- Is your patient covered by Medicare as an Aged Worker (Type 12) and claims for the patient are being submitted as Disability (Type 43)?
- Was your patient's injury related to Workers' Compensation (Type 15) and you billed the MSP claim as an Aged Worker (Type 12)?

If you utilize an electronic clearinghouse to submit your claims, make sure they are provided with the correct MSP Type. If you are still receiving rejections from Medicare, verify that your clearinghouse is submitting the MSP Type you gave them for your patients.

If you answered, "yes" to any of the above questions, your Medicare MSP claims are most likely rejecting because there is a mismatch of the type submitted and the Medicare MSP files. This situation can drastically impact the cash flow for your office. Below are the loops and segments where this information should be located in the electronic claims format:

Loop, Segment, Element	Description	Value
2000B, SBR, 05	Insurance Type Code	12, 13, 14, 15, 41, 42, 43, 47

- **Always submit the appropriate MSP type for the beneficiary's insurance coverage.**
- If an MSP type is submitted that does not correspond to the information Medicare has on file, your claim will be rejected. Rejected claims must be submitted as a new claim.

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Below is a list of the valid Medicare Secondary Payer types that may be submitted on electronic claims:

MSP Type	Description
12	Working Aged: age 65 or over, employer's group plan has at least 20 employees
13	End Stage Renal Disease (ESRD): 30-month initial coordination period in which other insurer is primary
14	No-Fault Situations: Medicare is secondary if illness/injury results from a no fault liability. <i>(This type would most likely not be submitted to Palmetto GBA because we will pay services conditionally, as primary, based on the provider's decision to bill Medicare for the Liability situation. In these cases, we do not require MSP information.)</i>
15	Workers' Compensation (WC) situations
41	Black Lung benefits
42	Veterans Administration (VA): either Medicare or VA may pay, not both
43	Disability: under age 65, person or spouse has active employment status and employer's group plan has at least 100 employees
47	Liability Situations: Medicare is secondary if illness/injury results from a liability situation

Helpful articles from our Web site under *Resources/Medicare Secondary Payer*:

- Electronic Claims: Valid MSP Types
- Electronic Submission of MSP Claims
- Submitting MSP Claims Electronically

Medicare Beneficiaries in State or Local Custody Under a Penal Authority

The Centers for Medicare & Medicaid Services (CMS) will deny claims for beneficiaries who are in custody of a State or local government under the authority of a penal statute at the time the provider rendered the service. This provision was implemented in Regulations 42 CFR 411.4(a) and 411.4(b) respectively.

Medicare excludes from coverage items and services furnished to beneficiaries in State or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, same vigor, as it pursues other debts.

- CMS presumes that a State or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in State or local government custody.

Regulations 42 CFR 411.4(b) states “Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
2. The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.”

Providers and suppliers who render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) must indicate this fact by using HCPCS modifier “QJ.”

- Definition of HCPCS modifier QJ: “Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b).”
- This modifier indicates that the provider has been instructed by the State or local government agency that requested the healthcare items or services provided to the patient that it is the policy of the State or local government that the prisoner/patient is responsible to repay the cost of Medical services, and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

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IMPORTANT:

- HCPCS modifier “QJ” must be entered in the first or second modifier field of Item 24D of the CMS-1500 claim form and in the appropriate field for electronic claims.
- Incarcerated dates of service should not be combined with non-incarcerated dates of service on the same claim.
- Social Security Administration (SSA) provides dates of incarceration to this carrier. The patient must contact his/her local Social Security office prior to requesting an appeal if the incorrect date is on file. Only Social Security can make this correction.

Example: Carrier’s record indicates the patient was incarcerated on January 15, 2008, but he/she was actually released January 10th. The Social Security office must correct their records before a claim can be processed correctly.

Appeal rights are given on claims denied in whole or part under this policy upon the initial receipt of the determination of the claim on the basis that on the date of service:

- The conditions of 42 CFR 411.4(b) were met.
- The prisoner/patient was not, in fact, in the custody of a State or local government under authority of a penal statute.

Signature Requirements: Change Request (CR) 5550 Clarification

Provider Types Affected

Physicians and other providers who bill Medicare Contractors (Carriers, Fiscal Intermediaries, Regional Home Health Intermediaries, Part A/B Medicare Administrative Contractors, including Durable Medical Equipment Medicare Administrative Contractors) for care provided to Medicare beneficiaries in hospice.

What You Need to Know

CR 5971, from which this article is taken, clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It provides that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness for hospice.

Make sure that your billing staffs are aware that, to document the certification of terminal illness for hospice, a facsimile of an original written or electronic signature is acceptable.

Background

CR 5971, from which this article is taken, clarifies the instructions in Medicare Program Integrity Manual Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) that address the signature requirements for the certification of terminal illness for hospice, that were provided in CR 5550 (Various Medical Review Clarifications).

Subsection 3.4.1.1B of the manual notes that Medicare contractors require a legible identifier for services provided/ordered. It further requires that when this documentation is for medical review purposes, the only acceptable method of documenting the provider signature is by written or an electronic signature. Stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

CR 5971 provides that there is an exception to this requirement.

It announces that a facsimile of an original written or electronic signature is acceptable for the certification of terminal illness for hospice. Please be sure to note however, that while a signature facsimile is acceptable in this instance; it and hard copies of a physician's electronic signature must be present in the patient's medical record.

Additional Information

You can find more information about the signature requirements for the certification of terminal illness for hospice by going to CR 5971, located at <http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf>. You will find updated Medicare Program Integrity Manual Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) as an attachment to this CR.

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

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Revised CMS-855 Medicare Enrollment Applications

Background

The Centers for Medicare & Medicaid Services (CMS) issued revised CMS-855 Medicare enrollment applications in March 2008. With the exception of providers enrolling as a specialty hospital on the CMS-855A, Medicare contractors will continue to accept the 2006 version of the Medicare enrollment application through June 2008. Providers and suppliers should begin to use the new Medicare enrollment applications immediately. Initially, these applications will be available only from the CMS provider enrollment Web site. The link for that CMS Web site is listed in the Additional Information section of this article. Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see Key Points below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

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

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

- Removed the requirement in Section 17 that providers attached their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.

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

- Removed the supplier type “Voluntary Health/Charitable Agency” from Section 2A.
- Clarified reporting timeframes throughout the CMS-855B.
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.
- Required that an Independent Diagnostic Testing Facility (IDTF) submit copies of its comprehensive liability insurance policy in Section 17.
- Added a list of the new IDTF standards found in 42 CFR 410.33(g) on a separate page in Attachment 2.
- Added instructions that explain the IDTF liability insurance requirements in 42 CFR 410.33(g)(6) to Attachment 2.

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

- Revised Section 2A2 to include a specific box that specialty hospitals must check when completing the application. Instructions explaining the definition of a “specialty hospital” were also added to the form.

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- Clarified the term “primary practice location” in the instructions in Section 4. (The clarification did not change any data elements on the form.)
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the data element “Medicare Year-End Cost Report Date” from Section 2.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.

Application-Specific Changes for DMEPOS Suppliers (CMS-855S)

- Added supplier standards 22 – 25 to the list of DMEPOS supplier standards found on page 31.

Additional Information

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

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

Medicare Shared Systems Modifications: Crossover to Medicaid National Drug Codes (NDC) and Corresponding Quantities Submitted on CMS-1500 Paper Claims

Provider Types Affected

All physicians, providers, and suppliers who submit paper claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)) for certain physician administered drugs provided to Medicare beneficiaries

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5835 that notifies physicians and suppliers who use Claim Form CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act (ASCA)) that changes are being made to Medicare systems to conform with instructions for submitting NDC drug code and quantity information on Form CMS-1500.

What You Need to Know

This article only applies to those providers eligible to submit paper claims and who do so for patients who are dually eligible for Medicaid and Medicare. Such claims need to include NDCs and corresponding quantity amounts for physician-administered drugs. The Key Points section of this CR outlines the changes required in the Form CMS-1500.

What You Need to Do

Make certain your office staffs are aware of these changes in the content requirements of your paper claims.

Background

The Deficit Reduction Act (DRA) of 2005 required State Medicaid agencies to provide for the collection of National Drug Codes (NDC) on all claims for certain physician-administered drugs for the purpose of billing manufacturers for Medicaid drug rebates. Prior to the DRA, physicians' offices, outpatient hospital departments and clinics generally used Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicaid for drugs dispensed to Medicaid patients. However, because State Medicaid agencies are required to invoice manufacturers for rebates using NDCs for drugs for which the States have made payments, often States were not able to fulfill the rebate requirements for physician-administered drugs. The requirements for the collection of NDCs became effective beginning January 1, 2007. In addition, beginning January 1, 2008, in order for Federal financial participation (FFP) to be available for these drugs, State Medicaid agencies must be in compliance with the requirements. These requirements were implemented in a final rule published on July 17, 2007.

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Also, the quantity field of the CMS-1500 paper claim should be captured on all crossover claims for Medicaid billing, as provided for by the National Uniform Claims Committee (NUCC). Information regarding the quantities of physician-administered drugs billed to Medicaid is also necessary for States to bill manufacturers for Medicaid drug rebates.

Key Points

When required to submit NDC drug number and quantity information for Medicaid rebates on the CMS-1500 paper claim be aware of the following:

- Submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999).
- Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six positions available for quantity. If the quantity is less than six positions, the entry should be left justified with spaces filling the remaining positions.

Additional Information

To see the official instruction (CR 5835) issued to your Medicare Carrier, DME/MAC, or A/B MAC refers to <http://www.cms.hhs.gov/Transmittals/downloads/R1401CP.pdf>.

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

Exception to 60-Day Limit on Substitute Physician Billing Arrangements for Physicians Called to Active Duty in the Armed Forces Reserves

Provider Types Affected

Physician members of a reserve component of the Armed Forces who bill Medicare Carriers or Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries.

Physicians called to active duty in the Armed Forces who wish to bill for substitute physician services during the physician's absence.

What You Need to Know

CR 5985, from which this article is taken, announces a 6-month extension of the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces. This means that a physician who is called to active duty may continue to bill for substitute physician services furnished from January 1, 2008 through June 30 2008, which may be beyond the 60-day limit.

Make sure that your billing staffs are aware of this change.

Background

Section 1842(b)(6)(D)(iii) of the Social Security Act (the Act) and Medicare Claims Processing Manual Chapter 1 (General Billing Requirements), Sections 30.2.10 (Payment Under Reciprocal Billing Arrangements - Claims Submitted to Carriers) and 30.2.11 (Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers) state that when a physician is unavailable to provide services, a substitute physician's services (either on a reciprocal or locum tenens basis) are not to be provided for a period longer than 60 continuous days.

On August 3, 2007, Public Law 110-54 amended the Act to provide an exception to this 60-day limit for physicians who are ordered to active duty in the Armed Forces.

By striking "January 1, 2008" and inserting "July 1, 2008," Section 116 of the "Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007" (signed on December 29, 2007) extended this exception for another 6 months.

CR 5985, from which this article is taken updates these sections in Medicare Claims Processing Manual to reflect this change in the law.

Effective January 1, 2008, physicians called to active duty will be able to bill for substitute physician services furnished from January 1, 2008, through June 30 2008.

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Additional Information

You can find more information about the exception to the 60-Day limit on substitute physician billing arrangements for physicians called to active duty in the Armed Forces reserves by going to CR 5985, located at <http://www.cms.hhs.gov/transmittals/downloads/R1486CP.pdf>. You will find the updated Medicare Claims Processing Manual Chapter 1 (General Billing Requirements), Sections 30.2.10 and 30.2.11 as an attachment to that CR.

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

New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Provider Types Affected

Any Medicare Fee-for-Service (FFS) provider that may be in a position of ordering, referring, or supplying DMEPOS to a Medicare beneficiary may be affected by this program. This includes DMEPOS suppliers, physicians (including podiatric physicians), other treating practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), physical and occupational therapists, and institutional providers (especially skilled nursing facilities and their social workers or care coordinators, hospitals and their discharge planners, home health agencies and pharmacists).

Note that those who refer or order DMEPOS for Medicare beneficiaries are being described as “referral agents” throughout this series.

Provider Action Needed

Impact to You

Effective July 1, 2008, Medicare will begin implementation of a new program for purchasing DMEPOS for Medicare patients. For Medicare beneficiaries whose permanent residence is in 1 of the 10 metropolitan statistical areas (MSAs) affected by the first phase of this program, only contract suppliers, in most instances, will be eligible to provide competitive bid items and receive payment from Medicare. While new payment rules may not impact referral agents directly, they may impact your patients. Therefore, the Centers for Medicare & Medicaid Services (CMS) is providing this information to make you aware of the program so you can discuss it with your patients when necessary.

What You Need to Know

This program, initially, will affect patients obtaining DMEPOS in 10 Competitive Bidding Areas (CBAs) that align with the 10 MSAs affected by the first phase of this program and will include 10 product categories of DMEPOS. These areas and product categories will be identified later in this article. In general, if your patients reside in one of the CBAs, they must use a Medicare contract supplier for competitive bid items, unless they are willing to be responsible for full payment of these items. This means that some of your patients may have to change from a noncontract supplier to a contract supplier. Also, certain suppliers that rent DMEPOS that were not awarded contracts may be “grandfathered” under this program and may be able to continue to supply certain DMEPOS items/services should the beneficiary choose to continue to receive these items from a grandfathered supplier.

What You Need to Do

It is important that all affected providers know this information. This program determines how much Medicare will pay for competitive bidding items and which suppliers are eligible to receive Medicare payments for these items. Be aware that the new program impacts payment amounts for certain DMEPOS

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items received by beneficiaries residing in one of the CBAs no matter where in the country they obtain their DMEPOS.

Be prepared for this program if you treat Medicare patients in one of the 10 areas affected by the first phase of this program, which are listed later in this article. Note that the program will expand to 70 additional MSAs in 2009.

Background

Currently, Medicare payment for most DMEPOS is based on fee schedules. Recent amendments to the Social Security Act (the Act), however, will alter the process for determining payment amounts for certain DMEPOS items. Specifically, Section 1847 of the Act mandates that competitive bidding payment amounts replace the current MEPOS fee schedule payment amounts for selected items in selected areas. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services. The new method brings the payment amount for these items in line with that of a competitive market and reduces your patients' out-of-pocket expenses. The program also ensures the availability of a sufficient number of accredited suppliers for access to quality items and services. For more information on accreditation of DME suppliers, visit

http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/04_New_Quality_Standards.asp.

The law also provides for phasing in competitive bidding beginning in 10 of the largest MSAs. The program will be expanded into 70 additional MSAs in 2009 and the program will be expanded into additional areas after 2009. Areas that may be exempt from competitive acquisition of DMEPOS include rural areas and areas with low population density that are not competitive, unless there is a significant national market through mail order for a particular item or service. An area is chosen for the Competitive Bidding Program based on several variables, including the size of its Medicare population and the amount of money spent on medical equipment and supplies in those areas.

Definitions

The following definitions are provided to explain several terms and their usage in this series of articles:

- Contract Supplier - An entity that is awarded a contract by CMS to furnish items under a competitive bidding program.
- Noncontract Supplier - A supplier that is not awarded a contract by CMS to furnish items included in a competitive bidding program.
- Referral Agents – This term applies to the range of physicians, practitioners or providers who prescribe DMEPOS (in essence, “order” or “refer”) for their patients.
- Grandfathered Supplier - A noncontract supplier that chooses to continue to furnish grandfathered items to a beneficiary in a CBA.
- Grandfathered Item - Any one of the items (as described in CFR §414.220, 222, 226, and 229) for which payment is made on a rental basis prior to the implementation of a competitive bidding program and for which payment is made after implementation of a competitive bidding program to a grandfathered

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supplier that continues to furnish the items in accordance with §414.408(j).

- Single payment amount means the allowed payment for an item furnished under a competitive bidding program.

For more information on single payment amounts, visit <http://dmecompetitivebid.com/SPA> on the Internet.

Initial Competitive Bidding Areas (CBAs)

Effective July 1, 2008, the competitive bidding program will be implemented in the following CBAs within these 10 MSAs:

- Charlotte-Gastonia-Concord, North Carolina and South Carolina;
- Cincinnati-Middletown, Ohio, Kentucky, and Indiana;
- Cleveland-Elyria-Mentor, Ohio;
- Dallas-Fort Worth-Arlington, Texas;
- Kansas City, Missouri and Kansas;
- Miami-Fort Lauderdale-Miami Beach, Florida;
- Orlando-Kissimmee, Florida;
- Pittsburgh, Pennsylvania;
- Riverside-San Bernardino-Ontario, California;
- San Juan-Caguas-Guaynabo, Puerto Rico.

Product Categories

Effective July 1, 2008, the competitive bidding program will be implemented for the following product categories:

- Oxygen supplies and equipment;
- Standard power wheelchairs, scooters, and related accessories;
- Complex rehabilitative power wheelchairs and related accessories;
- Mail-order diabetic supplies;
- Enteral nutrients, equipment, and supplies;
- Continuous positive airway pressure (CPAP), respiratory assist devices (RADs), and related supplies and accessories;
- Hospital beds and related accessories;
- Negative pressure wound therapy (NPWT) pumps and related supplies and accessories;
- Walkers and related accessories;
- Support surfaces (Group 2 mattresses and overlays (Miami MSAs only)).

Traveling Beneficiaries

As previously mentioned, any beneficiary obtaining competitive bidding items in one of the CBAs is affected by the rules of the Medicare DMEPOS Competitive Bidding Program. Beneficiaries who reside in a CBA and travels outside their CBAs may obtain competitive bid items and the supplier will be paid the single payment amount under the program.

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In addition, beneficiaries who do not reside in CBAs and who travel to CBAs are also affected. If they require competitive bid items, they must obtain competitive bid items from a contract supplier for that CBA. In such instances, Medicare will pay that contract supplier the DMEPOS fee schedule amount.

The following table details how DMEPOS supplies may be acquired, given different scenarios:

If a beneficiary permanently lives in...	And travels to...	Type of supplier a beneficiary may go to...
A competitive bidding area	A competitive bidding area	A beneficiary must get competitively bid items from a contract supplier located in the competitive bidding area to which he/she traveled.
A competitive bidding area	An area NOT covered by the competitive bidding program	A beneficiary may get items from any Medicare-enrolled DME supplier, and the supplier will be paid by Medicare as if it were in the beneficiary's competitive bidding area.
An area NOT covered by the competitive bidding program	A competitive bidding area	A beneficiary must get the competitively bid item from a contract supplier in the competitive bidding area. If the beneficiary does not use a contract supplier, the noncontract supplier must ask him/her to sign an Advance Beneficiary Notice. Medicare will not pay for competitively bid items furnished by noncontract suppliers.
An area NOT covered by the competitive bidding program	An area NOT covered by the competitive bidding program	A beneficiary may get items from any Medicare-enrolled DMEPOS supplier.

CMS is conducting extensive outreach to Medicare beneficiaries who reside in the CBAs and will be offering to help them identify contract suppliers.

If DMEPOS suppliers or referral agents are unsure whether a beneficiary resides in a CBA and is affected by this program effective July 1, they can make that determination by comparing the ZIP code of the patient's residence to the list of ZIP codes for the CBAs, which is available at [http://dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/DMEPOS%20Com petitive%20Bidding%20Areas%20Zip%20Codes?opendocument](http://dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/DMEPOS%20Com%20petitive%20Bidding%20Areas%20Zip%20Codes?opendocument).

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Payment

Payment for contract DMEPOS items will be the single payment amounts that were announced by CMS on March 20, 2008 (versus the current fee schedule determination of payment) for:

- Contract Suppliers, and
- Noncontract Suppliers that provide item to traveling beneficiaries.

Additional Information

DMEPOS suppliers should note that previous articles have explained the program in more detail as it relates to DMEPOS suppliers. MLN Matters article SE 0714, “Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program,” is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0714.pdf>. Also, MLN Matters article MM 5574, “Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program,” is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf>.

In addition, all providers may find more detailed information at <http://www.dmecompetitivebid.com> on the Internet and at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>.

As this is the first in a series of MLN Matters articles on this issue, further articles will be released in the very near future.

Grandfathering, Repair/Replacement, Mail Order Diabetic Supplies and Advance Beneficiary Notices (ABNs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

The second in a series of articles on the new DMEPOS competitive bidding program.

Provider Types Affected

Any Medicare Fee-for-Service (FFS) provider supplying DMEPOS to a Medicare beneficiary. This article also contains information of interest to those who order DMEPOS and to referral agents as defined in MLN Matters article SE 0805.

Provider Action Needed

The first article (SE 0805) in this series on the DMEPOS Competitive Bidding Program being instituted by the Centers for Medicare & Medicaid Services (CMS) presented an overview of how the program may affect your patients. There are also some key provisions of the program about which your patients may raise questions. While the competitive bidding program only affects ten areas of the country as of July 1, 2008, it will expand to 70 additional geographic areas in 2009. Thus, it is important for you to be familiar with this program.

MLN Matters article SE 0805, entitled “Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS),” which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf> on the CMS website, summarizes information on competitive bidding that may impact your patients. Article SE 0805 contains the list of competitive bidding areas for the first phase of competitive bidding as well as a list of the DMEPOS product categories that are included in the program’s initial implementation.

In using this series of DMEPOS articles, it is important to remember that in most instances, beneficiaries maintaining a permanent residence in one of the Competitive Bidding Areas (CBAs) must obtain competitive bidding items from a contract supplier. There are also program requirements that apply to beneficiaries who reside in CBAs but travel outside of those CBAs and to beneficiaries who do not live in CBAs but travel to them.

Grandfathered Suppliers

The Medicare DMEPOS Competitive Bidding Program requires Medicare beneficiaries to obtain competitive bidding items from a contract supplier, unless an exception applies. Therefore, in some instances, your patient may be required to change from a non-contract supplier to a contract supplier. However, the program does allow for certain suppliers to be “grandfathered.” Grandfathered suppliers are allowed to continue to provide certain rented DME items and services even though they are not contract suppliers.

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Grandfathering only applies when the patient is renting DME or oxygen equipment at the time the competitive bidding program becomes effective and the rental period for the item began before the start of the competitive bidding program.

Beneficiaries who are receiving oxygen, oxygen equipment or rented DME at the time the competitive bidding program becomes effective may elect to continue to receive these items from a non-contract supplier, if the supplier is willing to continue furnishing these items. If a non-contract supplier chooses not to be “grandfathered” or if a beneficiary wants to change to a contract supplier, the non-contract supplier must pick up the rental equipment and oxygen equipment. Unless a beneficiary relocates outside of the CBA and the supplier service area, the supplier cannot discontinue services by picking up a medically necessary item prior to the end of a rental month for which the supplier was eligible to receive a rental payment, even if the last day of a rental month is after the start date of the program. If the date of the beginning of a monthly rental period is prior to the start of the competitive bidding program, the supplier must submit a claim for that month. Note that the grandfathering provision also applies to Medicare beneficiaries who transition from a Medicare Advantage Plan to the Fee-for-Service program. If the beneficiary stays with a “grandfathered” supplier, he or she may elect to change to a contract supplier at any time, and the contract supplier would be required to accept the beneficiary as a customer. For more details on the grandfathering provision, visit <http://www.dmecompetitivebid.com>.

Repair and Replacement of Beneficiary-Owned Items

Repair ONLY

A beneficiary who owns a competitively bid item that needs to be repaired may have the repairs performed by either a contract supplier or by a non-contract supplier. In these cases, Medicare pays for reasonable and necessary labor not otherwise covered under a manufacturer’s or supplier’s warranty.

Repair and Replacement

If a part needs to be replaced in order to make the beneficiary-owned equipment serviceable, and the replacement part is also a competitively bid item for the CBA in which the beneficiary maintains a permanent residence, the part may be obtained from either a contract supplier or a non-contract supplier. In either case, Medicare pays the single payment amount provided under the Competitive Bidding Program for the replacement part.

Replacement ONLY

Beneficiaries maintaining permanent residences in a CBA are required to obtain replacement of all items subject to competitive bidding from a contract supplier. This includes replacement of base equipment and replacement of parts or accessories for base equipment that are being replaced for reasons other than servicing of the base equipment.

Beneficiaries who are not permanent residents of a CBA but require a replacement of a competitively bid item while visiting a CBA, must obtain the replacement item from a contract supplier. The supplier will be paid the fee schedule amount for the state where the beneficiary is a permanent resident.

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Mail Order Diabetic Supplies under the Program

Medicare beneficiaries who permanently reside in a CBA may purchase their diabetic testing supplies from:

- A mail order contract supplier for the area in which the beneficiary maintains a permanent residence; or
- A non-contract supplier in cases where the supplies are not furnished on a mail order basis.

The mail order contract period covers diabetic testing supplies furnished from **July 1, 2008 through March 31, 2010**. The term “mail order” refers to items ordered remotely (i.e., by phone, email, internet, or mail) and delivered to the beneficiary’s residence by common carriers (e.g., U.S. Postal Service, Federal Express, United Parcel Service) and does not include items obtained by beneficiaries from local supplier storefronts.

Mail order contract suppliers will be reimbursed at the single payment amount for the CBA where the beneficiary maintains a permanent residence.

For diabetic supplies that are not furnished through mail order, suppliers will be paid the fee schedule amount.

Medicare payment will not be made to non-contract suppliers that furnish mail order diabetic testing supplies to Medicare beneficiaries residing in a CBA. A special modifier, KL, will be used on each claim to indicate that the item was furnished on a mail order basis.

Note: Suppliers that furnish diabetic testing supplies on a mail order basis and do not attach the mail order modifier could be subject to significant penalties under the False Claims Act.

Both the Medicare program and beneficiaries will save money each time a mail order contract supplier is used; **however, it is solely up to the beneficiaries to decide whether or not they wish to obtain their diabetic testing supplies on a mail order basis.**

All mail order contract suppliers are required to report the manufacturer or make and model number of products they furnish and must update this list on a quarterly basis. This information will be made available to the public once the contract suppliers have been announced and will be updated on a routine basis. Contract suppliers will be required to make available the same range of products to Medicare beneficiaries that they make available to non-Medicare customers.

Advance Beneficiary Notice (ABN) Information

In general, if a non-contract supplier in a CBA furnishes a competitively bid item to any Medicare beneficiary regardless of whether that beneficiary maintains a permanent residence in the CBA or another area, and no applicable exceptions apply, Medicare will not make payment. In addition, the beneficiary is not liable for payment unless the non-contract supplier in a CBA obtains an ABN signed by the beneficiary.

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A signed ABN indicates that the beneficiary was informed in writing prior to receiving the item that there would be no Medicare coverage due to the supplier's contract status, and that the beneficiary understands that he/she will be liable for all costs that the non-contract supplier may charge the beneficiary for the item.

If a non-contract supplier furnishes a competitively bid item to a beneficiary and the beneficiary signs an ABN, the supplier must use the "GA" HCPCS modifier on their claim. If the "GA" HCPCS modifier is not present on the claim, the supplier may not hold the beneficiary liable for the cost of the item.

Additional Information

CMS contracted with the Competitive Bidding Implementation Contractor (CBIC) to administer the DMEPOS Competitive Bidding Program. Downloadable **Patient Education Fact Sheets** can be found at: <http://www.dmecompetitivebid.com/palmetto/CBIC.nsf/docsCat/CBIC~Referral%20Providers~Patient%20Education%20Fact%20Sheets?open&cat=CBIC~Referral%20Providers~Patient%20Education%20Fact%20Sheets>.

If you have concerns, questions, or complaints about the quality of an item or the service that a patient received from a contract supplier, please call the Competitive Bidding Program helpline at 1-877-577-5331.

For more information about the Competitive Bidding Program, call 1-877-577-5331. TTY users call 1-877-486-2048. Stay tuned for additional articles in this series. You can also visit <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/> or <http://www.dmecompetitivebid.com/> for more details.

Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Provider Types Affected

Suppliers of Durable Medical Equipment (DME) that wish to participate in the upcoming Medicare DMEPOS competitive bidding program.

Provider Action Needed

In order to participate in the second round of the DMEPOS Competitive Bidding Program, suppliers will be required to register in the Centers for Medicare & Medicaid Services (CMS) security system known as the Individuals Authorized Access to CMS Computer Services (IACS). This includes suppliers that bid in the first round of competition last year and are interested in competing in the second round. Although the bidding window for the second round of competition may not be announced before the issue date of this article, CMS urges suppliers planning to bid in the 2008 bidding cycle to make sure their provider enrollment record is current. Specifically, suppliers should verify their supplier number(s) and Authorized Official(s) information associated with that supplier number(s) on file with the National Supplier Clearinghouse (NSC). The accuracy of this data is critical for successful bid registration.

Background

In this year's bid cycle, suppliers who wish to bid will need to first register in IACS, before the bidding window opens. There will be three user roles available, which are described as follows:

- Authorized Official (AO) – Each supplier's organization will be allowed one AO. The AO role can approve all other users associated with their organization who are requesting access to the bidding system. The AO will be able to input bid data, approve Form A and certify Form B in the bidding system.
- Backup Authorized Official (BAO) - Each supplier organization will be allowed to designate one or more Backup Authorized Officials (BAOs). In this role, the BAO can approve the supplier's End User registration for access to the bidding system. Like the AO, the BAO can also input bid data, approve Form A and certify Form B in the bidding system.
- End User - Each supplier organization will be allowed one or more End User(s). The End User can input bid data, but cannot approve Form A or certify Form B.

Save Time and Delay by Verifying NSC Information Prior to Registering to Bid

Only those AOs listed on the CMS-855S (Medicare Enrollment Application) as an AO can register in IACS to approve and certify as described above. As part of the CMS-855S, a supplier designates one or more AO(s). The AO is an appointed official to whom the organization has granted the legal authority to enroll it in the Medicare program and to commit the organization to fully abide by the statutes, regulations and program instructions of the Medicare program.

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End Users do not need to be listed on the CMS-855S. However, the AO or BAO will need to approve an End User's request for access to the bidding system.

Take Action Now

Be sure that the data you are submitting is current and in accordance with that submitted to the NSC. In particular, this concerns the AO's name, date of birth, Social Security Number (SSN), and mailing address. If any of these data elements have changed since your last submission to the NSC, then you should PROMPTLY complete a change of information on the CMS 855-S.

CMS urges that suppliers do it now. The NSC processing time to complete a change of information on the CMS-855S is approximately 45 days and all submissions are processed in the order in which they are received.

Overview of AO IACS Registration Process

For an AO, the verification of his/her last name, date of birth and SSN must be validated against the data maintained by NSC. The NSC received this AO data when the supplier completed their most recent CMS-855S Medicare Enrollment Application. The AO's last name is listed in Section 15 and the AO's date of birth and SSN in Section 6A of the CMS-855S. If the data does not match, the registration will be rejected.

Following successful registration, as an added measure of security, the AO's User ID and password is then mailed in a separate correspondence to the mailing address listed in Section 2A2 of the CMS-855S Medicare Enrollment Application.

The BAO goes through a similar process and an AO for the organization must approve a BAO's request for access before a User ID and password will be emailed to the BAO.

Do I need a BAO role?

The establishment of a BAO is highly recommended to avoid any disruption in the bidding process. The AO's role is instrumental to bidding, as the AO's role must be active to avoid all other users of the organization from losing access to the bidding system. If the AO leaves the organization, the BAO role can be changed to an AO role by the Competitive Bidding Implementation Contractor (CBIC).

You will want to verify that the CMS-855S Medicare Enrollment Application for your organization has two or more AOs listed.

Additional Information

For more information on the DMEPOS competitive bidding program, visit <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>.

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Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Important Exceptions and Special Circumstances

Provider Types Affected

The following providers may be affected by this program:

- Physicians and other treating practitioners who are Medicare enrolled DMEPOS suppliers;
- Physicians and others who order or refer DMEPOS items or services for their patients;
- Skilled nursing facilities (SNFs) and nursing facilities (NFs); and
- Physical therapists and occupational therapists in private practice who are Medicare enrolled DMEPOS suppliers.

Many Medicare Fee-for-Service (FFS) providers may be in a position of ordering, referring, or supplying DMEPOS to a Medicare beneficiary. This includes physicians (including podiatric physicians), other treating practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), physical and occupational therapists, and institutional providers (especially skilled nursing facilities and their social workers or care coordinators, hospitals and their discharge planners, home health agencies and pharmacists).

Provider Action Needed

Understand these special program rules that may affect you. This article is especially important if you are a Medicare enrolled DMEPOS supplier of items governed by the new program, even if you are not located in a competitive bidding area (CBA). It is important to understand that the program affects any beneficiaries who permanently reside in or travel to CBAs. Some program requirements apply to beneficiaries who reside in CBAs even if these beneficiaries travel outside their CBAs. Thus, it is important for you to be familiar with this program.

While the first phase of the competitive bidding program only affects ten CBAs in the country as of July 1, 2008, the second phase will expand to 70 additional geographic areas in 2009. See MLN article SE0805 for information about CBAs and items governed by this new program and for information about how the program applies to traveling beneficiaries.

Background

MLN Matters article SE 0805 that is entitled, “Overview of New Medicare Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS),” and is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf>, summarizes information on competitive bidding that may impact your patients. Article SE 0805 contains the list of competitive bidding areas for the first phase of competitive bidding as well as a list of the DMEPOS product categories that are included in the program’s initial implementation.

MLN Matters article SE 0806 that is entitled, “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Grandfathering, Repair and Replacement, Mail Order

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Diabetic Supplies and Advanced Beneficiary Notices (ABNs),” which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf>, provides an overview of the rules regarding grandfathered suppliers, repair and replacement of beneficiary-owned equipment, mail order diabetic supplies under the program, and ABNs.

In this, the third in a series of articles on the new DMEPOS competitive bidding program, we provide information on some special circumstances and exceptions of particular interest to physicians and other treating practitioners, SNFs and NFs, and physical and occupational therapists in independent practice.

Note: It is important to note that the Competitive Bidding Program does not affect your patients’ choice of physician or treating practitioner.

In using this series of DMEPOS articles, remember that in most instances, beneficiaries maintaining a permanent residence in one of the Competitive Bidding Areas (CBAs) must obtain competitive bidding items from a contract supplier. There are also program requirements that apply to beneficiaries who reside in CBAs but travel outside of those CBAs and to beneficiaries who do not live in CBAs but travel to them.

Physicians and Other Treating Practitioners Who are Enrolled Medicare DMEPOS Suppliers

Medicare physicians and treating practitioners who have also enrolled as Medicare DMEPOS suppliers via the 855S enrollment form have the option to furnish certain types of competitively bid items to their own patients without submitting a bid or being awarded a competitive bid contract, provided the following requirements are met:

- For the first phase of the program being implemented July 1 2008, the item furnished must be a walker. In the future, the items will be limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps that are DME;
- The items must be furnished by the physician or treating practitioner DMEPOS supplier to his or her own patients as part of his or her professional service; and
- The items must be billed to a DME MAC using the DMEPOS billing number that is assigned to the physician, the treating practitioner (if possible), or a group practice to which the physician or treating practitioner has reassigned the right to receive Medicare payment.

Where the furnished item is a bid item and the beneficiary resides in a CBA, the physician or treating practitioner will be paid the single payment amount established by this program for the item. This exception does not affect the applicability of the physician self-referral (Stark law) provisions in section 1877 of the Act. All provisions of the physician self-referral law remain fully in effect.

Physicians and Other Treating Practitioners Who Prescribe Specific Brand or Mode of Delivery to Avoid an Adverse Medical Outcome

A physician (including a podiatric physician) or treating practitioner may prescribe, in writing, a particular brand of DMEPOS bid item or mode of delivery for an item if he or she determines that the particular brand or mode of delivery would avoid an adverse medical outcome for the beneficiary. The physician or

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treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

In these cases, the contract supplier under the Competitive Bidding Program must:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) Specialty Suppliers

The DMEPOS Competitive Bidding Program applies to SNFs and NFs to the extent that their residents receive competitively bid items under Medicare Part B. Unlike most suppliers, SNFs and NFs have the option to bid for, and be awarded, contracts to be "specialty suppliers" that only furnish competitively bid items to their own residents. SNFs and NFs that become specialty suppliers may not furnish competitively bid items and services to Medicare beneficiaries outside their facilities for purposes of Medicare payment. SNFs and NFs can also become regular contract suppliers that furnish competitively bid items to beneficiaries throughout a CBA.

If a SNF or NF is not a contract supplier (either a specialty contract supplier or a regular contract supplier), it must use a contract supplier for its CBA to furnish competitively bid items to its residents.

Physical Therapists and Occupational Therapists in Private Practice Who are Enrolled Medicare DMEPOS Suppliers

Physical therapists and occupational therapists in private practice who are enrolled DMEPOS suppliers may eventually have the option to furnish certain types of competitively bid items to their own patients and be paid the single payment amount for such items without being contract suppliers, provided the following requirements are met:

- The items are limited to off-the-shelf (OTS) orthotics; and
- The items must be furnished only to their own patients as part of the physical or occupational therapy service.

Note: OTS orthotics are not included in the first phase of competitive bidding, this exception is not relevant in the first phase of the DMEPOS Competitive Bidding program beginning July 1, 2008.

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Additional Information

If you have concerns, questions, or complaints about the quality of an item or the service that a patient received from a contract supplier please call the Competitive Bidding Program helpline at 1-877-577-5331.

For more information about the Competitive Bidding Program, call 1-877-577-5331. TTY users call 1-877-486-2048. Stay tuned for additional articles in this series. You can also visit <http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home> and at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>.

Allergen Immunotherapy to Medicare Beneficiaries: Use of Professional Society Practice Parameters

Provider Types Affected

All physicians and providers who submit Medicare claims for providing Allergen Immunotherapy to Medicare Beneficiaries

Provider Action Needed

This special edition (SE) article SE 0812 is in response to recommendations made by the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) in its 2006 “Allergen Immunotherapy for Medicare Beneficiaries” report. This article provides guidance and resources, developed by professional societies, for Medicare contractors and providers in determining the most appropriate provisions of allergen immunotherapy to Medicare beneficiaries.

Background

The Centers for Medicare & Medicaid Services (CMS) does not have a national coverage determination (NCD) that identifies national coverage criteria for allergen immunotherapy services. Currently coverage of allergen immunotherapy services is at the local Medicare contractor’s discretion. The February 2006 “Allergen Immunotherapy for Medicare Beneficiaries” report released by the DHHS, OIG identified areas of Medicare vulnerability due to insufficient available information regarding coverage, coding, and documentation requirements for physicians who provide allergen immunotherapy to Medicare beneficiaries.

Key Points

- Because allergen immunotherapy may vary significantly based on geographical locations, CMS, with the support of the Joint Council of Allergy, Asthma, and Immunology (JCAAI), decided that an NCD was not the best mechanism for providing coverage to beneficiaries throughout the nation.
- CMS determined that contractor discretion for coverage of allergen immunotherapy is most appropriate.
- Without an NCD, Medicare contractors may develop their own local coverage determinations (LCDs).
- While these policies may vary between contractors, CMS strongly encourages physicians who provide allergen immunotherapy to closely follow practice parameters agreed upon and endorsed by the professional societies that represent allergy, asthma, and immunology practitioners (like the Joint Council of Allergy, Asthma, and Immunology (JCAAI)), as long as those parameters fall within the coverage criteria of applicable LCDs.
- Specific practice parameters are provided on the JCAAI Web site at <http://www.jcaai.org/> and are important for all practitioners and providers to study and understand.

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Additional Information

The CMS Web site provides a searchable database of LCDs, which is available at <http://www.cms.hhs.gov/mcd/search.asp>.

Providers may also wish to review the Medicare NCD Manual, which is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

Drugs: New HCPCS Codes April 2008 Update

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5981, which instructs Medicare Contractors to implement Healthcare Common Procedure Coding System (HCPCS) code changes effective April 1, 2008. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the Healthcare Common Procedure Coding System (HCPCS) code set on a quarterly basis.

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7602	Albuterol inh non-comp con	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)
J7603	Albuterol inh non-comp u d	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)
J1751	Iron dextran 165 injection	INJECTION, IRON DEXTRAN 165, 50 MG
J1752	Iron dextran 267 injection	INJECTION, IRON DEXTRAN 267, 50 MG

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will be payable for Medicare:

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HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1MG
J7612	Levalbuterol non-comp con	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG
J7613	Albuterol non-comp unit	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 1MG
J7614	Levalbuterol non-comp unit	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG
Q4096	VWF complex, NOS	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO
Q4097	Inj IVIG Privigen 500 mg	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Q4098	Inj iron dextran	INJECTION, IRON DEXTRAN, 50MG
Q4099	Formoterol fumarate, inh	FORMORETOL FUMARATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

Currently, Alphanate® is the only product that should be billed using HCPCS code Q4096. HCPCS code J7190 should continue to be billed when Alphanate® is furnished for purposes of administering Factor VIII. The blood clotting furnishing fee is payable when payment is allowed for Q4096. When a payment allowance limit for HCPCS code Q4096 is included on the quarterly Part B drug pricing files, the payment allowance limit will include payment for the blood clotting furnishing fee.

Effective for dates of service on or after April 1, 2008, the requirements under CR 5713 (See the MLN Matters article for CR 5713, which is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5713>.

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pdf) are being updated by CR 5981 to apply to claims that bill Intravenous Immunoglobulins (IVIG) using HCPCS code Q4097 as follows:

Effective for dates of service on or after April 1, 2008, Medicare Contractors will:

- Only pay a claim for preadministration-related services HCPCS code(s) (G0332) associated with IVIG administration if G0332, the drug (IVIG, HCPCS codes: J1566, J1568, J1569, J1561, J1572 and/or Q4097), and the drug administration service are all billed on the same claim for the same date of service;
- Return institutional claims for HCPCS code(s) G0332 to the provider if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not also billed for the same date of service on the same claim;
- Reject professional claims as unprocessable for HCPCS code(s) G0332 if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not billed for the same date of service on the same claim; and
- Use the appropriate reason/remark messages such as: M67 “Missing other procedure codes” and/or 16 “Claim/service lacks information” which are needed for adjudication when claims are returned/rejected.

Additional Information

The official instruction, CR 5981, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding these changes may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1492CP.pdf>.

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

Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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FREE Evaluation & Management Medicare Part B Seminars: Ashtabula, Ohio

Palmetto GBA is presenting a FREE Evaluation & Management Seminar in Ohio 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.

Date	Location	Time
Wednesday, May 14, 2008	Ashtabula County District Library 335 West 44th Street Ashtabula, Ohio 44004	10:00 a.m. – 12:30 p.m.
Wednesday, May 14, 2008	Ashtabula County District Library 335 West 44th Street Ashtabula, Ohio 44004	1:00 p.m. –3:30 p.m.

Registration:

To Register for a seminar go to:

- <http://www.PalmettoGBA.com/boh/education> (Ohio)
- 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.

FREE Evaluation & Management Medicare Part B Seminars: Podiatry

Palmetto GBA is presenting a FREE Evaluation & Management Seminar in Ohio 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 as well as podiatry examples.

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

Date	Location	Time
Thursday, May 15, 2008	St. Elizabeth Health Center 8401 Market Street Boardman, Ohio 44512	9:00 a.m. – 11:30 a.m.

Registration:

To Register for a seminar go to:

- <http://www.PalmettoGBA.com/boh/education> (Ohio)
- 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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Medicare Part B Small Provider Forums: Point Pleasant, West Virginia

Palmetto GBA is sponsoring a General Medicare Part B Seminar in Point Pleasant, West Virginia on June 17th designed for small providers. These forums are specifically designed for providers with fewer than 10 full time employees. The sessions will include Medicare updates and reimbursement changes and be followed by a question and answer session. All specialties are welcome!

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

How to Register

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

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

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

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 for Palmetto GBA Small Provider Forums

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

Name: _____

Practice Name: _____

Practice Address: _____

Telephone: _____

Fax Number: _____

Forum you wish to attend:

_____ June 17, 2008, Point Pleasant, West Virginia

Name and number of persons attending: _____

To Be Completed by Palmetto GBA

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

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

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2008 Medicare Physician Fee Schedule Database (MPFSDB): April 2008 Update

Provider Action Needed

This article is based on Change Request (CR) 5980 which amends payment files previously issued to Medicare contractors based upon the 2008 Medicare Physician Fee Schedule Final Rule. CR 5980 also includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

Background

Attachment 1 of CR 5980 contains changes included in the April Update to the 2008 MPFSDB, and CR 5980 can be reviewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf>. Specific changes are detailed in Attachment 1 of CR 5980 and are summarized as follows:

CPT/HCPCS code revisions

A number of CPT/HCPCS codes have been modified to reflect revised bilateral indicators, Relative Value Unit (RVU) revisions, or procedure status changes retroactive to January 1, 2008.

Reinstated J HCPCS Codes

A number of J HCPCS Codes (J7611 through J7614) are reinstated with a status indicator of “E” and the reinstated codes are effective for dates of service on or after April 1, 2008. Descriptors and payment indicators for the reinstated codes are in attachment 1 of CR 5980.

New Q HCPCS Codes

There are several new Q HCPCS codes (Q4096 through Q4098) with a status indicator of “E” and which are effective for dates of service on or after April 1, 2008. The codes with their descriptors are in the following table:

HCCPS Code	Long Descriptor	Short Descriptor
Q4096	Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor (Not Otherwise Specified), Per I.U. VWF: RCO	VWF complex, not Humate-P
Q4097	Injection, Immune Globulin (Privigen), Intravenous, Non-Lyophilized (E.G., Liquid), 500 mg	Inj IVIG Privigen 500 mg
Q4098	Injection, Iron Dextran, 50 mg	Inj iron dextran
Q4099	Formoterol fumarate, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms	Formoterol fumarate, inh

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New Category II Codes for PQRI

There are new Category II codes for the PQRI for dates of service on or after April 1, 2008. These new codes and their descriptors are in the following table:

CPT Code	Long Descriptor	Short Descriptor
0525F	Initial visit for episode	Initial visit for episode
0526F	Subsequent visit for episode	Subs visit for episode
1130F	Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, AND employment status	Bk pain + fxn assessed
1134F	Episode of back pain lasting six weeks or less	Epsd bk pain for =< 6 wks
1135F	Episode of back pain lasting longer than six weeks	Epsd bk pain for > 6 wks
1136F	Episode of back pain lasting 12 weeks or less	Epsd bk pain for <= 12 wks
1137F	Episode of back pain lasting longer than 12 weeks	Epsd bk pain for > 12 wks
2040F	Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications	Bk pn xm on init visit date
2044F	Documentation of mental health assessment prior to intervention (back surgery or epidural steroid injection) or for back pain episode lasting longer than six weeks	Doc mntl tst b/4 bk trxmnt
3330F	Imaging study ordered	Imaging study ordered (bkp)
3331F	Imaging study not ordered	Bk imaging tst not ordered
3340F	Mammogram assessment category of “incomplete: need additional imaging evaluation”, documented	Mammo assess inc xray docd
3341F	Mammogram assessment category of “negative”, documented	Mammo assess negative docd

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CPT Code	Long Descriptor	Short Descriptor
3342F	Mammogram assessment category of “benign”, documented	Mammo assess bengn docd
3343F	Mammogram assessment category of “probably benign”, documented	Mammo probably bengn docd
3344F	Mammogram assessment category of “suspicious”, documented	Mammo assess susp docd
3345F	Mammogram assessment category of “highly suggestive of malignancy”, documented	Mammo assess hghlymalig doc
3350F	Mammogram assessment category of “known biopsy proven malignancy”, documented	Mammo bx proven malig docd
4240F	Instruction in therapeutic exercise with follow-up by the physician provided to patients during episode of back pain lasting longer than 12 weeks	Instr xrcz 4bk pn >12 weeks
4242F	Counseling for supervised exercise program provided to patients during episode of back pain lasting longer than 12 weeks	Sprvsd xrcz bk pn >12 weeks
4245F	Patient counseled during the initial visit to maintain or resume normal activities	Pt instr nrml lifest
4248F	Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer	Pt instr–no bd rest>= 4 days
4250F	Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	Wrmng 4 surg - normothermia
5060F	Findings from diagnostic mammogram communicated to practice managing patient’s on-going care within 3 business days of exam interpretation	Fndngs mammo 2pt w/in 3 days
5062F	Findings from diagnostic mammogram communicated to the patient within 5 days of exam interpretation	Doc f2fmammo fndng in 3 days

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CPT Code	Long Descriptor	Short Descriptor
6040F	Use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, documented	Appro rad ds dvcs techs docd
6045F	Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented	Radxps in end rppt4fluro pxd
7020F	Mammogram assessment category [eg, Mammography Quality Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA approved equivalent categories] entered into an internal database to allow for analysis of abnormal interpretation (recall) rate	Mammo assess cat in dbase
7025F	Patient information entered into a reminder system with a target due date for the next mammogram	Pt infosys alarm 4 nxt mammo

Revised Descriptors for PQRI Codes

Attachment 1 of CR 5980 also contains a list of editorial changes to the short and/or long descriptors for a number of PQRI codes.

April Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB)

Effective April 7, 2008, for dates of service performed on or after January 1, 2008, the Centers for Medicare and Medicaid Services (CMS) have made changes to the following CPT codes and CPT codes with HCPCS modifier on the 2008 Medicare Physician Fee Schedule Database (MPFSDB).

The following are revisions to the current MPFSDB:

			NON-FACILITY SETTING			FACILITY SETTING		
CPT Code	HCPCS Modifier	State	PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
93501		OH	\$808.24	\$767.83	\$883.00	\$808.24	\$767.83	\$883.00
		WV	\$749.41	\$711.94	\$818.73	\$749.41	\$711.94	\$818.73
93501	TC	OH	\$649.99	\$617.49	\$710.11	\$649.99	\$617.49	\$710.11
		WV	\$593.98	\$564.28	\$648.92	\$593.98	\$564.28	\$648.92
93508		OH	\$949.56	\$902.08	\$1,037.39	\$949.56	\$902.08	\$1,037.39
		WV	\$872.57	\$828.94	\$953.28	\$872.57	\$828.94	\$953.28

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			NON-FACILITY SETTING			FACILITY SETTING		
CPT Code	HCPCS Modifier	State	PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
93508	TC	OH	\$725.66	\$689.38	\$792.79	\$725.66	\$689.38	\$792.79
		WV	\$653.69	\$621.01	\$714.16	\$653.69	\$621.01	\$714.16
93510		OH	\$1,448.17	\$1,375.76	\$1,582.12	\$1,448.17	\$1,375.76	\$1,582.12
		WV	\$1,344.45	\$1,277.23	\$1,468.81	\$1,344.45	\$1,277.23	\$1,468.81
93510	TC	OH	\$1,212.27	\$1,151.66	\$1,324.41	\$1,212.27	\$1,151.66	\$1,324.41
		WV	\$1,113.73	\$1,058.04	\$1,216.75	\$1,113.73	\$1,058.04	\$1,216.75
93526		OH	\$1,875.47	\$1,781.70	\$2,048.96	\$1,875.47	\$1,781.70	\$2,048.96
		WV	\$1,744.09	\$1,656.89	\$1,905.42	\$1,744.09	\$1,656.89	\$1,905.42
93526	TC	OH	\$1,548.10	\$1,470.70	\$1,691.31	\$1,548.10	\$1,470.70	\$1,691.31
		WV	\$1,423.85	\$1,352.66	\$1,555.56	\$1,423.85	\$1,352.66	\$1,555.56
93642		OH	\$484.42	\$460.20	\$529.23	\$484.42	\$460.20	\$529.23
		WV	\$457.63	\$434.75	\$499.96	\$457.63	\$434.75	\$499.96

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

Additional Information

The official instruction, CR 5980, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf>.

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

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April 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Provider Types Affected

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

What You Need to Know

CR 5982, from which this article is taken, instructs Medicare contractors to download and implement the April 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2008, January 2007, April 2007, July 2007, October 2007, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of 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 has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

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- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of “not otherwise classified, (NOC)” HCPCS codes.

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 of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent 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 OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

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 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are 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 Ambulatory Payment Class (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 of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished

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incident to a professional service. The payment allowance limits will not be updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPSS where the payment allowance limit is 95 percent of the published AWP.

In determining the payment limit based on WAC, the contractors follow the methodology specified in Pub. 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent 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. For 2008, the blood clotting furnishing factor of \$0.158 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 and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

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On or after March 18, 2008, the April 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after March 18, 2008, the April 2008 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR 5982 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007
April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007
October 2006 ASP and ASP NOC files	October 1, 2006, through December 31, 2006

NOTE: The absence or presence of a 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 makes these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians 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.

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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. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR 5982) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R1484CP.pdf>.

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

Important Evaluation & Management (E/M) Coding Reminder

GROUP PRACTICES

This article serves as an important reminder of the long standing policy for physicians in a group practice.

Remember:

Physicians in the same group practice who are in the same specialty MUST bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for UNRELATED problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

- If the reason for the second visit is an unrelated problem that could not have been addressed in the first encounter, the reason for the second visit must be clearly documented in the documentation field of the electronic claim or as an attachment to the CMS 1500 Claim Form.
 - Example: Identify when a provider is practicing in an unrecognized subspecialty (e.g. EP, retinal specialist, hand surgery, etc.) and list the diagnosis code that is unrelated to the other E/M service for the same date.
- If denied, you may request a Redetermination including documentation so that Palmetto GBA can reconsider payment for the second visit.
- Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

For more information, please refer to Centers for Medicare & Medicaid Services (CMS) IOM Manual, Pub 100-04, Chapter 12, Section 30.6.5. <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>.

Nursing Facility Services

Provider Types Affected

Physicians and qualified non-physician practitioners who bill Medicare contractors (Carriers or Medicare Administrative Contractors A/B MAC) for services provided to Medicare beneficiaries in skilled nursing facilities (SNF) or nursing facilities (NF)

What You Need to Know

CR 5986, from which this article is taken, updates the Medicare Claims Processing Manual, Chapter 12, (Physicians/Non-physician Practitioners), Section 30.6.13 (Nursing Facility Services (CPT Codes 99304 - 99318) Subsection F (Use of the Prolonged Services Codes and Other Time-Related Services) by noting that the typical/average time units for Evaluation and Management (E/M) visit codes in the Nursing Facility Services code family are reestablished and applicable, as of January 1, 2008.

Effective for services on or after July 1, 2008, you may bill Medicare for medically necessary prolonged services for E/M visits (CPT codes 99356 and 99357) in a SNF or NF with Nursing Facility Services CPT codes (99304 – 99306, 99307 – 99310 and 99318). Additionally, you may use these prolonged services CPT codes (99356 and 99357) with Nursing Facility Services in the CPT code range (99304 – 99306, 99307 – 99310, and 99318) to bill for counseling and/or coordination of care services that are based on time.

Make sure that your billing staffs are aware of these new billing changes.

Background

Effective January 1, 2006, the American Medical Association (AMA) Current Procedural Terminology (CPT) Panel removed the typical/average time units for evaluation and Management (E/M) services in the Nursing Facility code family.

Until these typical/average times were reestablished, this action precluded the billing of:

- 1) prolonged services for E/M visits in a skilled nursing facility or nursing facility; and
- 2) time-based counseling and/or coordination of care for Nursing Facility Services.

CR 5986, from which this article is taken, updates the Medicare Claims Processing Manual, Chapter 12, (Physicians/Non-physician Practitioners), Section 30.6.13 (Nursing Facility Services (CPT codes 99304 - 99318)), Subsection F (Use of the Prolonged Services Codes and Other Time-Related Services) by announcing that the AMA CPT Panel has reestablished these typical/average time units beginning January 1, 2008.

Further, CR 5968 announces that, effective July 1, 2008, you may bill for medically necessary prolonged services for SNF or NF E/M visits (CPT codes 99356 and 99357) with Nursing Facility Services (CPT code range 99304 – 99306, 99307 – 99310 and 99318); and you may also use the medically necessary prolonged services CPT codes (99356 and 99357) to bill for medically necessary E/M visits for time-based

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counseling and/or coordination of care for Nursing Facility Services in the CPT code range 99304 – 99306, 99307 – 99310, and 99318.

Additional Information

You can find more information about using the prolonged services codes CPT codes (99356 and 99357) billing for medically necessary prolonged services for E/M visits in a SNF or NF, and for time-based counseling and/or coordination of care for Nursing Facility Services by going to CR 5968, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1489CP.pdf>. You will find the updated Medicare Claims Processing Manual, Chapter 12, (Physicians/Non-physician Practitioners), Section 30.6.13 (Nursing Facility Services (CPT codes 99304 - 99318) Subsection F (Use of the Prolonged Services Codes and Other Time-Related Services) as an attachment to that CR.

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

Vertebral Axial Decompression (VAX-D)

The Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 2, Section 160.16 states that vertebral axial decompression is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvis and/or cervical traction connected to a special table that permits the traction application. There is insufficient scientific data to support the benefits of this technique. Therefore, vertebral axial decompression is not covered by Medicare.

There are various types of VAX-D devices including but not limited to: VAX-D, DRX-3000, DRX9000, Decompression Reduction Stabilization (DRS) System, IDD, MedX, Spina System, Accu-Spina System, SpineMED Decompression Table, Lordex Traction Unit, Triton DTS and the Z-Grav. Regardless of the manufacturer of the device, vertebral axial decompression is not a covered service under the Medicare program.

Additionally, providers are not to utilize physical therapy Current Procedural Terminology (CPT) codes 97001 through 97799 or surgical CPT code 64722 to report vertebral axial decompression services on claims submitted to Medicare.

You are not required to file claims for non-covered Medicare services. However, many Medicare supplemental insurance policies pay for services that Medicare does not allow and they may require a Medicare denial notice. Therefore, if you provide vertebral axial decompression services to your patients, the correct code to submit for the denial is Healthcare Common Procedure Coding System (HCPCS) code S9090 (vertebral axial decompression, per session).

Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes: April 2008 Update

Provider Types Affected

Providers (ASCs) who submit claims to Medicare Administrative Contractors (A/B MACs) and carriers, for services provided to Medicare beneficiaries which are paid under the ASC payment system.

Provider Action Needed

This article is based on Change Request (CR) 5994 which describes changes to, and billing instructions for, payment policies implemented in the April 2008 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals.

Key Points

Billing for Drugs and Biologicals

- ASCs are strongly encouraged to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products must make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.
- If commercially available drug and biological products are being mixed together to facilitate their concurrent administration, the ASC should report the quantity of each product (reported by HCPCS code) that is separately payable in the ASC used in the care of the patient. Alternatively, if the ASC is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, the payment is packaged and no HCPCS coding is required. In these situations, ASCs should not report HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the Food and Drug Administration (FDA) on or after January 1, 2004, for which a HCPCS code has not been assigned.

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective April 1, 2008

- Payments for separately payable drugs and biologicals based on the ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates for previous quarters (January 2008) are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the April 2008 release of the ASC DRUG FILE.
- Your Medicare contractors will make available to the ASCs the list of any newly added codes and previous quarter payment rate changes as identified in CR 5994.
- Providers take note that if your claims were processed prior to the installation of the revised January 2008 ASC Drug file, your Medicare AB/MAC or carrier will adjust, as appropriate, claims you bring to their attention that have dates of service on or after January 1, 2008 but prior to April 1, 2008.

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New HCPCS Drug Codes Separately Payable under the ASC Payment System as of April 1, 2008

Four new HCPCS codes have been created effective April 1, 2008. These new HCPCS codes and their descriptors are listed in Table 1 below.

Table 1
New Drugs Separately Payable under the ASC Payment System as of April 1, 2008

HCPCS Code	Long Descriptor
C9241	Injection, doripenem, 10 mg
Q4096	Injection, Von Willebrand Factor Complex, human, Ristocetin Cofactor (Not otherwise specified), per I.U. VWF:RCO
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
Q4098	Injection, iron dextran, 50 mg

The payment rates for the drugs in Table 1 can be found in the April 2008 update of the ASC Addendum BB which will be posted on the CMS Web site at the end of March.

HCPCS Drug Codes No Longer Payable under the ASC Payment System Effective April 1, 2008

The following drug codes have been deleted and are no longer payable by Medicare, effective April 1, 2008.

Table 2
Drugs HCPCS codes no longer eligible for payment under Medicare as of April 1, 2008

HCPCS Code	Long Descriptor	ASC Payment Status
J1751	Injection, iron dextran 165, 50 mg	Not payable by Medicare
J1752	Injection, iron dextran 267, 50 mg	Not payable by Medicare

Correct Reporting of Units for Drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

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- For example, if the drug's HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be 1.
- As another example, if the drug's HCPCS descriptor specifies 50 mg and 200 mg of the drug were administered to the patient, the units billed should be 4.
- ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only 1 vial was administered.
- HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Additional Information

To see the official instruction (CR 5994) issued to your Medicare Carrier or A/B MAC go to <http://www.cms.hhs.gov/Transmittals/downloads/R1488CP.pdf>.

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

Update to Audiology Policies: National Provider Identifier (NPI)

IMPORTANT - Delay of Enrollment Requirement for Audiologists

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

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

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

Clinical Laboratory Fee Schedule: Medicare, Medicaid and State Children's Health Insurance Program (MMSCHIP) Legislation

Provider Types Affected

Clinical laboratories billing Medicare contractors (carriers, fiscal intermediaries, or Part A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 5987 which alerts clinical laboratories that, effective for tests furnished on or after April 1, 2008, the MMSCHIP Extension Act of 2007 sets payment for CPT codes 83037 and 83037 HCPCS modifier QW (Hemoglobin; glycosylated (A1c) by device) by crosswalking it to be the same as CPT code 83036 (glycosylated (A1c)). Make certain your billing staffs are aware of this change.

Background

The MMSCHIP Extension Act of 2007 passed in December 2007 and included Section 113. Section 113 of the legislation set the price for any diagnostic test for HbA1C that is labeled by the Food and Drug Administration (FDA) for home use equal to the payment rate for a glycosylated hemoglobin test (identified as of October 1, 2007, by CPT code 83036 (and any succeeding codes)). The legislation is effective for tests furnished on or after April 1, 2008.

- For Calendar Year (CY) 2006, the Current Procedural Terminology (CPT) established new CPT code 83037 Hemoglobin; glycosylated (A1C) by device cleared by the FDA for home use. CPT code 83036, glycosylated (A1c), already existed and was priced at \$13.56 on the clinical laboratory fee schedule.
- For calendar year 2006, CMS determined that CPT code 83037 should be paid via carrier gap filling.
- For calendar year 2007, CMS set the payment for CPT code 83037 by crosswalking it to code 82985 (Glycated protein).
- For tests furnished on or after April 1, 2008, the payment for CPT codes 83037 or
- CPT code 83037 HCPCS modifier QW will be the same as the payment on the clinical laboratory fee schedule for CPT code 83036.

Your Medicare contractor will adjust claims for services on or after April 1, 2008, processed prior to implementation of this change if you bring such claims to the contractor's attention.

Additional Information

To see the official instruction (CR 5987) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R331OTN.pdf>.

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

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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

LCD	Change	Effective Date
Sedation and Analgesia by Non-anesthesiologists. 2007-02L	New Policy: The Center for Medicare and Medicaid Services' (CMS) position change as published in CR 5618, which allows physician payment for CPT codes 99143-99145 provided the procedure with which the sedation is billed is not listed in Appendix G of the CPT Coding Guidelines. Since there were many questions on these new billable codes, OH/WV Medicare Part B is establishing physician guidelines for medical record documentation.	04/01/2008
Cardiac Computed Tomography & Angiography (CCTA) 2006-01LR3	Revised Policy: Title change from Computed Tomography Angiography of the Coronary Arteries to Cardiac Computed Tomography & Angiography. Criteria and verbiage changes were added to the Indications and Limitations section for acute chest pain, chest pain syndrome, intracardiac and extracardiac structures and congenital heart disease were added. Expanded and clarified Limitation section, clarifying the specifications for a CT device, verbiage change regarding Ultrafast CT and EBT/EBCT, calcium scoring; limitation regarding CTCA for obstructive CAD, pulmonary embolism, etc.; added definition of intermediate risk. Added Acceptable levels of Competence for Performance and Interpretation of CCTCA to Appendices Section of the LCD. Added additional references to Sources of Information section. CPT Codes added to expand coverage (0145T, 0147T, 0148T, 0149T, 0150T and 0151T). Expanded ICD-9 Codes to include: 402.00-402.91, 411.1, 411.81, 412,414.10, 414.19, 414.9, 415.0, 415.11, 415.19, 416.0-416.9, 417.0-417.9, 420.0-420.99, 424.0, 424.0, 424.1, 425.0-425.5, 425.7-425.9, 426.10-426.13, 426.2-426.4, 426.50-426.54, 426.6, 426.7, 426.81, 426.89, 426.9, 427.0-427.2, 427.31-427.32, 427.41-427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 427.9, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9, 429.2, 429.3, 435.2, 440.0, 441.00, 441.01, 444.1, 518.5, 786.05, 794.30-794.31, 996.02, 996.03, 996.1, V42.1, V42.2, V45.81 for CPT Codes 0145T-1049T and 0151T. ICD-9 codes were added for CPT code 0150T the include the following: 745.0, 745.10, 745.11, 745.12, 745.19, 745.2, 745.3, 745.4, 745.5, 745.60, 745.61, 745.69, 745.7, 745.8, 745.9, 746.00-746.09, 746.1-746.7, 747.0, 747.10, 747.11, 747.20-747.22, 747.29,747.3, 747.40-747.42, 747.49, 747.81-747.89, 748.9, 786.05, 786.3, 786.50,786.51, 786.59, 786.6, 794.2, 794.30, 794.31.	06/01/2008

Continued on next page

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Continued from previous page

LCD	Change	Effective Date
Non -Covered Category III CPT codes. 2007-01LR3	Revised policy: Removal of CPT codes 0145T, 0147T, 0148T, 0149T, 0150T and 0151T as they are now addressed in the Cardiac Computed Tomography & Angiography (CCTA) LCD.	06/01/2008
Chemotherapy and Biologicals 2002-29LR40	Addition of ICD-9 codes 204.10 and 204.11 as supporting medical necessity for HCPCS code J9999 Bendamustine Hydrochloride; Treanda. Effective for FDA approval date of 03/20/2008.	05/01/2008
Diagnostic Cardiac Catheterization 2000-44LR10	Revision Made: Removed the CMS National Coverage Policy reference to IOM Publication 100-3 Chapter 1 Section 20.25 as this NCD was repealed effective 01/12/2006.	01/12/2006

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

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



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

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

General Information

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

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

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

Date of initial determination: _____ Provider Phone Number: _____

*Date of Service: _____ Who are you:

*CPT code(s): _____ Provider

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

Billed Charge: _____ Patient with Medicare

Patient's Representative

Other

This is an appeal for:

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

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

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

Reason for request: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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

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Reconsideration Request Form - QIC North (Ohio)

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

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

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

Contractor Number: 00883

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

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Reconsideration Request Form - QIC South (West Virginia)

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

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

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

Contractor Number: 00884

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

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Contact Center

1-877-567-9232 (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 Beneficiary Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

<http://www.PalmettoGBA.com>

Important Sources For You

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

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

Attention: Billing Manager

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