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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2006, Issue 10

www.cms.hhs.gov

www.PalmettoGBA.com

October 2006

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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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E-mail Inquiries Now Easier to Send!

It is now easier to send an email question to Palmetto GBA.

Click on “Contact Us” at to top of www.PalmettoGBA.com/boh (Ohio) or www.PalmettoGBA.com/bwv (West Virginia) Web page to submit questions or comments about a specific Medicare topic. There are different areas to direct your inquiries. Please choose the most appropriate area for handling your inquiry. To accurately assist you and to ensure that your inquiry is not delayed, please review the entire listing available before making your selection.

Please do not submit any personally identifiable information, including Medicare Health Insurance Claim Number (HIC), by e-mail.

Note: Old e-mail addresses will be discontinued after November 1, 2006.

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Medicare Publication Subscription

This is to inform you that your subscription to the Palmetto GBA Medicare Publications has expired with this Advisory.

Between October 2006 and September 2007, we anticipate publishing twelve *Medicare Advisories* and occasional Special Notices. Subscription copies will be mailed first class, assuring timely delivery. The cost for a twelve-month subscription is \$100.00. If you wish to continue your subscription, please complete the subscription form located at the back of this publication..

Please make your check or money order payable to: Palmetto GBA, and send to:

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PALMETTO GBA
PO BOX 182934
COLUMBUS OH 43218-2934

The Palmetto GBA Medicare Web site contains *Advisories* from the past four years. The current and past Physician Fee Schedules and Clinical Diagnostic Laboratory Fee Schedules are also available. From the Palmetto GBA Web site, you can view and print the *Advisories* free of charge. Palmetto GBA can e-mail you the latest Medicare updates on the topics that interest you, free of charge. Registration is easy: go to our Web site at <http://www.PalmettoGBA.com>. Select E-Mail Updates and then Register Now. For customized delivery, be sure to select the topics that apply to you.

Medicare Part B Small Provider Forum

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

Where: Ashtabula County District Library
335 West 44th Street
Ashtabula, Ohio 44004

When: Wednesday October 18, 2006

Time: 1:00PM to 4:00PM

Don't miss out on this Medicare educational forum to find out the latest Medicare changes and how they may affect you!! Seating is limited. Reservations are required and will be accepted on a first-come, first-served basis.

Internet access:

To register for a seminar please go to:

- ✓ www.PalmettoGBA.com/boh/education for Ohio or www.PalmettoGBA.com/bwv/education for West Virginia
- ✓ Workshops

You will need to login with your username and password to register. In order to register for a seminar, you must first create a username and password. For additional questions please call 1-877-567-9232 option 7, and then option 4.

No Internet access?

If you do not have Internet access, you may register for this event by faxing the attached registration form to 614-473-6812.

If you have any additional questions you may contact us at 1-877-567-9232 and selecting the option for education.

We look forward to meeting with you!

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Palmetto GBA Sponsored Training Seminar: National Provider Identifier (NPI)

- Date: October 19, 2006
- Location: Geneva Public Library
860 Sherman Street
Geneva, Ohio 44041
- Time: 3:00PM to 6:00PM
- Audience: All providers and staff, all specialties
- Cost: FREE! Advance registration is required.

During the workshop, we will address the following topics:

NPI Information for Health Care Providers

- o Training on the NPI that will assist providers with self-education, as well as education for their staff. This training will also be useful to national and local medical societies

NPI General Information

- o A basic overview of the NPI

Electronic File Interchange (EFI), or “bulk enumeration”

- o Provide details on the EFI process and information for Electronic File Interchange Organizations (EFIOs)

Subparts

- o Provide overall information on Subparts, as well as illustrations of common situations where Subparts may exist
- o Data Dissemination and Medicare Implementation
- o Tips for Health Care Professionals
- o Preparing Your Office Staff for NPI Guidance for Organization Health Care Providers Who Apply for NPIs for Their Health Care Provider Employees
- o Using the National Plan and Provider Enumeration System (NPPES) Web-based process

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Register via the Internet

- o Access the Palmetto GBA Web site at <http://www.PalmettoGBA.com/boh/education> (Ohio) or <http://www.PalmettoGBA.com/bwv/education> (West Virginia).
- o Log in with your username and password before registering. If you do not have a username, you must create one before you register through the Internet.
- o For additional questions please call 1-877-567-9232 and then selecting the option for education.

No Internet access?

If you do not have Internet access, you may register for this event by faxing the attached registration form to 614-473-6812.

We look forward to meeting with you!

Free Therapy Services Medicare Part B Seminars

Palmetto GBA is presenting **FREE Therapy Services Seminars** in Ohio and West Virginia designed for Physical Therapists, Occupational Therapists, and Speech Language Pathologists. Representatives from Palmetto GBA will provide the latest Medicare documentation guidelines for Therapy Services and the Therapy CAP Exception Process.

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

Ohio Seminars

Date	Location	Time
Tuesday, November 28, 2006	Spring Hollow Lodge 1069 W. Main St. Westerville, OH 43081 Cannot be accessed from Sharon Woods entrance. Continue north on Cleveland Avenue, past the main park entrance to Main Street and turn left. Go about 1.5 miles and turn left into the park. Follow the park signs.	1:00 p.m. - 3:00 p.m.

West Virginia Seminars

Date	Location	Time
Wednesday, September 27, 2006	Holiday Inn US 50 and Interstate 77 Parkersburg, WV 26101	1:00 p.m. - 3:00 p.m.

Registration:

To Register for a seminar please go to:

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

You will need to login with your username and password to register. In order to register for a seminar, you must first create a username and password. For additional questions please call 1-877-567-9232, then select the option for education.

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Free Chiropractic Services Medicare Part B Seminar

Palmetto GBA is presenting a FREE Chiropractic Services Seminar in Ohio designed for Chiropractors. Representatives from Palmetto GBA will provide the latest Medicare documentation guidelines for Chiropractic Services.

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

Ohio Seminars

Date	Location	Time
Tuesday, November 28, 2006	Spring Hollow Lodge 1069 W. Main St. Westerville, OH 43081 Cannot be accessed from Sharon Woods entrance. Continue north on Cleveland Avenue, past the main park entrance to Main Street and turn left. Go about 1.5 miles and turn left into the park. Follow the park signs.	9:30 a.m. - 11:30 a.m.

Registration:

To Register for a seminar please go to:

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

You will need to login with your username and password to register. In order to register for a seminar, you must first create a username and password. For additional questions please call 1-877-567-9232 and select the option for education.

Revised CMS-1500 Claim Form

The Centers for Medicare & Medicaid Services (CMS) has revised the CMS-1500 claim form to accommodate the new National Provider Identifier (NPI) numbers.

Alternatives to using the new CMS-1500 claim form

- Only providers that qualify for a “waiver” may submit paper claims to Palmetto GBA. The most common reason providers qualify for waivers is that they are considered small providers (10 or fewer full time equivalent (FTE)). All other providers must submit claims electronically to Medicare. This includes claims for which Medicare is the secondary payer.
- Even if you qualify to submit paper claims, you can still benefit from submitting electronically! Electronic claims may be paid as soon as 13 days after the claim is submitted, while paper claims are not paid until at least 29 days after the claim is received by Palmetto GBA.
- Call our EDI Support Line at 866-308-5438 and start submitting your claims electronically using PC Ace Pro32 software, for free.

Where can I order new forms?

- You can obtain new forms the same way you obtain current (version 12-90) forms. Call the Government Printing Office at 202-512-1800 to purchase the forms.
- Palmetto GBA cannot supply you with these forms.

When must I begin using the new CMS-1500 claim form?

Claims Submission Date	Requirement
Beginning January 2, 2007	<ul style="list-style-type: none"> ○ Health plans, clearinghouses, and other information support vendors must start using the new form.
January 2 through March 30, 2007	<ul style="list-style-type: none"> ○ Medicare providers (physicians, practitioners, and suppliers) may use the new form (version 08-05) or the old form (version 12-90) for any paper claims. ○ We strongly recommend that you submit both your NPI and PIN during this time.
April 2, 2007 and after	<ul style="list-style-type: none"> ○ All Medicare providers must use the new form for any paper claims. ○ We strongly recommend that you continue to submit both your NPI and PIN. (The NPI will be required on claims submitted to Medicare on and after May 23, 2007.)

What are the major changes from the old form?

- The biggest difference between the two forms is a split provider identifier field. The split fields will

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allow you to report your NPI in a dedicated field and your “legacy number” (PIN) in the unlabeled block above each NPI field.

Resources

- *MLN Matters* article #MM5060 provides additional information regarding the new CMS-1500 claim form. Read the full text of the article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf>.
- For complete instructions on completing the new CMS-1500 claim form, refer to the CMS Internet Only Manuals, Pub. 100-04, Chapter 26: <http://www.cms.hhs.gov/manuals>.

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Revised CMS-1500 Claim Form: Providers Excluded From Mandatory Electronic Claims Submission Requirements

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM 5060 at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM 5060 article supersede the dates in this article and MM 5060 conforms with CR 5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf>.

Important Points to Remember

CR 4293 describes the claim form **CMS-1500 (12-90)** that is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named **CMS-1500 (08-05)**. The following timeline outlines the schedule for using the revised CMS-1500 claim form:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.
- October 1, 2006 – January 31, 2007: Providers can use either the current CMS-1500 (12/90) version or the revised CMS-1500 (08/05) version of the claim form.
- February 1, 2007: The current CMS-1500 (12/90) version of the claim form is discontinued; only the revised CMS-1500 (08/05) form is to be used. All rebilling of claims should use the revised CMS-1500 (08/05) form from this date forward, even though earlier submissions may have been on the current CMS-1500 (12/90) claim form.

Background

The Form CMS-1500 form answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program and is accepted only from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

The CMS-1500 (12-90) claim form is being revised to accommodate the reporting of the National Provider Identifier (NPI). The intent of the new form is to best accommodate the NPI with minimal changes to the current claim form. The CMS-1500 (08-05) version will be effective October 1, 2006, but will not be mandated for use until February 1, 2007. Therefore, there will be a period when the current and the revised forms will both be acceptable.

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

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Implementation

The implementation date for the instruction is October 2, 2006

Additional Information

The official instructions issued to your Intermediary regarding this change can be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R899CP.pdf>.

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

You may also wish to review MLN Matters articles:

- **SE 0555**, “Medicare’s Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI- Related Activities” available on CMS’ Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf>; and/or
- **SE 0528**, “CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs” available on CMS’ Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf>.

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

Note: This article was revised on September 18, 2006, to reflect that CR5060 was revised. The transmittal number, CR release date, and the Web address for accessing CR5060 were revised. All other information remains the same.

Key Points

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

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

Background

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

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of

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benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

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

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

Billing Guidelines

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

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

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

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

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

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

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

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

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

National Provider Identifier (NPI): Electronic Claims “Correction to Information Required in Block 33”

As previously stated, beginning October 2, 2006, and through May 22, 2007, Medicare will begin accepting either an existing legacy Medicare billing number (a/k/a Medicare Provider Identification Number or Medicare PIN) and/or a National Provider Identifier (NPI) on claims. If only the NPI is submitted, the system will attempt to crosswalk the NPI to a legacy PIN. **In order for Palmetto GBA to crosswalk your NPI to the correct PIN, the address that you submit in Block 33 must reflect your practice address and NOT the place where the service was performed as previously instructed unless both happen to be at the same location.** Also, during this transition period, Medicare strongly recommends that when you submit an NPI, that you also continue to submit the Medicare Legacy Identifier (PIN) on the claim in order to prevent rejection or delay in payment of the claim.

Please keep in mind that this information will not apply to the revised CMS-1500 (08/05) paper claim form until January 1, 2007.

Important Guidance Regarding National Provider Identifier (NPI) Usage in Medicare Claims

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

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

Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007. Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in Interactive Voice Response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of

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

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

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

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

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

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

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

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

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

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Reporting of the Pay-to Address in the Billing Provider (2010AA) Loop

Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010AA (billing provider) loop, rather than in the 2010AB (pay-to-provider) loop.

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

Reporting of the Name and Address of a Billing Provider in the 2010AA Loop of an X12 837-I (Institutional) Electronic Claim

FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010AA loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

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

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

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

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

Additional Information

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as

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well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007. **Note:** Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

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

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier. Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.
- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

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

You can find more information about the National Provider Identifier (NPI) by going to the NPI page at http://www.cms.hhs.gov/apps/mpi/01_overview.asp. In addition, if you have any questions on the NPI, you may call our office at 1-877-567-9232.

National Provider Identifier: Correction of Business Requirement 4320.19

Impact on Providers

This article is based on change request CR 5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific National Provider Identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs. Prior to May 23, 2007, providers should report the Medicare legacy identifiers of those providers enrolled to submit claims to Medicare, as well as their NPI.

Note: Pending Medicare implementation of the UB-04 and the revised CMS-1500, providers are not to report NPIs on the current paper claim forms. If not already available, the following information will be posted on your local Medicare contractor's Web site, or included in provider newsletters from your local Medicare contractor:

Adjustments to edits to be applied when an NPI is included in an electronic data interchange (EDI) transaction; and

Actions that can be taken by claim and 276 submitters to avoid rejection of their transactions as result of these edits, and information about how to correct and resubmit a transaction if the transactions are rejected as result of these edits.

Additional Information

CR 4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" can be located on CMS' Web site at <http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf>.

MM 4320, the similarly titled Medicare Learning Network (MLN) article associated with CR 4320, is found on CMS' Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf>.

CR 5217 is the official instruction issued to your Medicare carrier/DMERC/DME MAC/FI/RHHI regarding changes mentioned in this article. CR5217 may be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R235OTN.pdf>.

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

Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM 5060 at <http://www.cms.gov/MLN MattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM 5060 article supersede the dates in this article and MM 5060 conforms with CR 5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CPT.pdf>.

Provider Action Needed

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005. Applications can be made by mail and also online at <https://nppes.cms.hhs.gov>.

NPI and Legacy Identifiers

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.

Legacy provider identifiers include:

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

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They **do not** include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs); or
- Social Security Numbers (SSNs).

Primary and Secondary Providers

Providers are categorized as either “primary” or “secondary” providers:

- **Primary providers** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- **Secondary providers** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk

During Stage 2, Medicare will utilize a Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this Crosswalk include the following:

- Each primary provider’s NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The Crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare Crosswalk will be updated daily to reflect new provider registrations.

NPI Transition Plans for Medicare FFS Providers

Medicare’s implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

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Stage	Medicare Implementation
January 3, 2006 - October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim . Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007: (This is stage 2, the subject of CR4023)	<p>CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider’s NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.</p> <p><i>Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.</i></p> <p>Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.</p>
May 23, 2007 – Forward:	CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
- X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
- National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
- Claims submitted using Medicare’s free billing software;
- Electronic claim status request received via X12 276 or DDE screen; and
- Non-X12 electronic claim status queries;
- An NPI reported cannot be located in Medicare files;

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- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI;
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

Note: If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

Additional Information

X12 837 Incoming Claims and COB

During Stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For Stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During Stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006, and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

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Pending the start of submission of the revised CMS-1500 and the UB-04, **providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.**

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. “Old” form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider’s NPI and legacy identifier when both are available in Medicare’s files. If a provider’s NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

- CR 4023 Attachment 1: FI Standard Paper Remit (SPR) Amended Format for Stage 2; and
- CR 4023 Attachment 2: Carrier/DMERC SPR Amended Stage 2 Format.

Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during Stage 2.

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

In-Depth Information

Please refer to CR 4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions

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- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR 4023, the official instruction issued to your FI/ regional home health intermediary (RHII) or carrier/ durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to CMS' Web site at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 4023 in the CR NUM column on the right, and click on the file for that CR.

You may also wish to review *Medlearn Matters* article SE 0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available on CMS' Web site at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0555.pdf>. This article contains further details on the NPI and how to obtain one.

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

National Provider Identifier (NPI): Modification of Editing Requirements

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

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

During Stage 2 of the NPI implementation process (October 2, 2006 - May 22, 2007), Medicare will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

Primary and Secondary Providers

Providers, for NPI provider identifier editing purposes, are categorized as either “primary” or “secondary” providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

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Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. **Secondary providers may be enrolled, but are not required to be enrolled in Medicare** (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

Secondary Provider Claims

Claims Submitted with NPI and Medicare Legacy Identifier:

During Stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider. (See MM 4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate Unique Provider Identification Number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a National Supplier Clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier Provider Identification Number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

Claims Submitted with NPI Only:

The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in the 10th position is correct), and whether there is a Medicare Provider Identifier Crosswalk entry for that NPI.

If the NPI is located in the Crosswalk:

- The Taxpayer Identification Number (TIN) (Employer Identification Number (EIN) or Social Security Number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare Provider Identifier Crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the Crosswalk:

- No supplemental identifier can be reported to a COB payer.
- However, the claim **will not be rejected** if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare Provider Identifier Crosswalk, with one exception. Reporting

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of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the Crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare Legacy Identifier Only

- A Medicare contractor may, but is not required to check a legacy number against the Medicare Provider Identifier Crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

COB and Medigap Trading Partners

Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a “secondary” provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

837-I or 837-P version 4010A1 Claims

Attachment 1 to CR 4320 which is being revised as part of CR 5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier “if known.” Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those “if known” types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

Note that “secondary” providers such as a referring/ordering physician are not required to be enrolled in Medicare as a **condition for payment** of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries **when those services are billed, paid-to or rendered by “primary” providers**. For example, Medicare could pay:

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider “under arrangements” even if that other provider is not enrolled in Medicare.

Implementation Date

The implementation date for this instruction is October 2, 2006.

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Additional Information

CR 4320, issued February 1, 2006, “Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms” is located at <http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf>.

The associated MLN article (with the same title) MM 4320, can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf>.

CR 4023, dated November 3, 2005, “Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms” is located at <http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf>. MM 4023, the associated MLN article, is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf>.

CR 5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR 5229 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf>.

If you have questions, please contact your local Medicare carrier/DMERC (DME MAC if appropriate), or FI/RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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

Provider Action Needed

Impact to You

The November 2005 through February 2006 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes (RARCs) and the X12N 835 Health Care Claim Adjustment Reason codes (CARCs).

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has developed a new Web site located at <http://www.cmsremarkcodes.info/> on the CMS Web site, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new Web site does not replace the Washington Publishing Company (WPC) Web site, <http://www.wpc-edi.com/codes>, as the official site where the most current RARC list resides. Use the list posted at the **WPC Web site** if there are any discrepancies between code text listed either on the new Web site or in this article, and the code text provided on the WPC Web site.

What You Need to Do

Please refer to the *Background* section of this article for a summary of the RARC and CARC code text changes.

Background

Among the codes sets mentioned in the Implementation Guide for transaction 835 (Health Care Claim Payment/Advice), the following two code sets must be used to report payment adjustments and related information for transaction 835 and the standard paper remittance advice for Medicare:

- Claim Adjustment Reason Code (CARC); and Remittance Advice Remark Code (RARC).

Additionally, for the coordination of benefits (COB) transaction (837), the CARC must be used. Both of these code sets are updated three times a year, and Medicare issues recurring Change Requests (CRs) that capture the changes in these code sets that have been approved in the previous four months.

Summary of Current Updates (November 1, 2005 – February 28, 2006 Changes) Remark Code (RARC) Changes

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New: The following code table reflects new remark codes:

New Code	Current Narrative
N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	The claim information has been forwarded to a Health Savings Account processor for review.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

Modified: Remark Code **MA02** was modified effective December 29, 2005. Its modified narrative is:

“If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.”

This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated: Code **MA03** was deactivated effective October 1, 2006. Remark code MA02 may be used instead.

Reason Code (CARC) Changes

New: The following table reflects new reason codes:

New Code	Current Narrative	New as of:
193	Original payment decision is being maintained. This claim was processed properly the first time.	February 2006
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician.	February 2006

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New Code	Current Narrative	New as of:
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service.	February 2006

Implementation Date

These code changes will be applied by your Medicare carrier/DMERC/FI/RHHI by October 2, 2006.

Additional Information

CR 5212 is the official instruction issued to your Medicare carrier/DMERC/FI/RHHI regarding changes mentioned in this article. CR 5212 may be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1031CP.pdf>.

For more information on the process used to update these two codes sets, see the *MLN Matters* article, MM 44314, available on CMS' Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4314.pdf>.

Please contact our office at 1-877-567-9232 if you have questions about this article.

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Overpayments and Refunds: Reminder

The acceptance of a voluntary refund as repayment for claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Palmetto GBA Medicare has received an increasing amount of refund payments that are being dismissed and returned because the requests did not include the reason for collecting the refund. It is very important that pertinent information is received with a refund payment.

To avoid any unnecessary adjustment to Medicare reimbursement and to assist us in processing refunds in a timely manner, we recommend that you follow the steps listed below when submitting refunds to Medicare Part B:

Voluntary Refund (when the reason for the refund is NOT due to the Medicare Secondary Payer reasons)

- Complete the Refund/Overpayment Form with **all** required information. The form is located at the back of the Advisory or you can access the form from our Web site, <http://www.PalmettoGBA.com/boh> (Ohio) or <http://www.PalmettoGBA.com/bwv> (West Virginia). Select forms located under Resources.
- Submit a completed CMS-1500 claim form, if you originally filed the claim on paper.
- Include a check for the exact amount of the overpayment. If part of the payment was correct, refund only the portion that was paid in error.

Voluntary Refund (when the reason for the refund IS due to Medicare Secondary Payer reasons)

When you identify an overpayment due to the other insurance that is primary to Medicare, the following information must be submitted with the refund check or the notification of a possible overpayment.

- **A copy of the entire primary insurance remittance for the service(s) in question.**
- Primary insurance information:
 - Insurance Company Name
 - Insurance Company Address
 - Insured's Name
 - Employee's ID Number
 - Primary Payer's Allowance
 - Primary Payer's Payment
 - Any Coinsurance and Deductible (if applied)

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- **Medicare Secondary Payer reason for overpayment** – Please identify the appropriate reason as listed below:
 - Group Health Plan
 - No Fault Insurance
 - Liability Insurance
 - Workers Compensation
 - Black Lung
 - Veterans Administration
 - ESRD
 - Other Insurance Involvement (please identify)

Additional Medicare Secondary Payer information is available on the Palmetto GBA Web site. The address is: <http://www.PalmettoGBA.com/boh> (Ohio) or <http://www.PalmettoGBA.com/bwv> (West Virginia), go to Resources and then select Medicare Secondary Payer.

Medicare Requested Refund

- Submit a copy of the overpayment request letter received from Medicare Part B. This is needed to identify correct patient and claim.
- Submit a check for the amount requested, made payable to **MEDICARE**, to the address listed below.

Please note: if we do not receive your payment by the date specified in the letter, we will withhold the amount, including interest, from future Medicare checks.

Please mail both voluntary and Medicare requested refunds to the following address:

Palmetto GBA
Medicare Part B
P.O. Box 182934
Columbus, OH 43218-2934

REMINDER: All refund checks must be made payable to MEDICARE.

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Physician Voluntary Refund Letter

Recently, AdvanceMed mailed letters to approximately 7,000 providers regarding voluntary refunds. The letters are associated with refund checks received by Palmetto GBA during calendar year 2005.

The Centers for Medicare & Medicaid Services (CMS) requires us to contact providers that voluntarily refund Medicare, using very specific language. If you received such a letter, please be aware that the intent is similar to a “disclaimer,” notifying you that submitting a voluntary refund does not exempt you from audit activity. As the Program Safeguard Contractor for Ohio and West Virginia, we reserve the right to investigate suspected inappropriate payments in an effort to protect the Medicare Trust Fund, even though a provider or entity may have refunded money to Medicare.

We encourage you to continue to perform self-audits and to refund payments received in error to the Trust Fund. We fully support these efforts and we are available to answer questions related to voluntary refunds. Please contact us at 614-801-0495 with any questions.

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24-Hour Rule: Medical Record Documentation

What you should know regarding medical records for dates of service that do not correspond to the date submitted on the claim.

Palmetto GBA is clarifying instructions regarding medical record documentation for dates of service that do not correspond to the date billed, but are within a 24-hour period. The Centers for Medicare & Medicaid Services (CMS) provided the CERT (Comprehensive Error Rate Testing) contractor with guidance in processing these claims. We support and adhere to the directions CMS has provided on this rule and have outlined this clarification below.

On occasion, a provider may submit a claim showing that the service was provided on a particular date while the medical record indicates that the service was actually provided up to 24 hours before or after the date of service on the claim. For example, the date of service listed on the claim may be for an Emergency Room visit on 1/24/06 while the medical record may indicate that the service was actually provided on 1/25/06. If the provider indicates that he/she does not have a medical record for the day in question (1/24/06), but he/she does have a medical record for the day before or the day after, the provider should submit the 1/25/06 record in support of the service billed as 1/24/06.

In all instances, appropriate consideration is given to all documentation that is provided. Documentation maintained in the medical record must support the medical necessity of the item(s) or service(s) submitted.

When a claim is subjected to pre-payment medical review, the documentation is reviewed on an individual basis for that particular date of service. If several dates of service are being reviewed, and documentation provided is of a limited basis, the documentation cannot be used to cover all dates of service, unless all dates of service are provided. For example, documentation for dates of service 2/1/06 through 2/3/06 is provided for review. The claim was submitted for dates of service 2/1/06 through 2/4/06. In this instance, the documentation would only cover the first three dates. Documentation for 2/3/06 would not be used for both 2/3/06 and also for 2/4/06, as this would be an incorrect application of the 24 Hour Rule. Therefore, because no documentation would be available to cover the 2/4/06 date of service, the service for this date would be denied.

Repeat or Duplicate Services on the Same Day

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

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

When a correction is needed on a previously paid service, do not submit as a new claim. Palmetto GBA can “reopen” these claims, at your request. Please write to:

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

Or you may call 1-866-308-5441.

Minor claim corrections can also be reopened by calling our telephone reopening line at 1-866-308-5441 Monday-Friday 9 A.M. to 12 P.M. and 1 P.M. to 3 P.M.

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

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

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

Example:

Patient receives two chest x-rays on October 1, 2005, interpreted by the *same physician*. The first interpretation is performed at 10:00 a.m. and the interpretation of the second x-ray is performed at 1:30 p.m.

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Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	71010-26	2

Modifiers

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

Site Modifiers:

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

Example:

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

Submit as:

Date of Service	CPT Code/HCPCS Modifier	Days/Units
10/1/05	28010-T1	1
10/1/05	28010-T3	1

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

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

Example:

Patient receives three chest x-rays on October 1, 2005, by the *same physician*. The first x-ray is performed at 10:00 a.m., the next one at 12:00 p.m., and a follow-up x-ray is performed at 1:30 p.m.

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	71020	1
10/1/05	71020-76	2

OR submit as:

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Date of Service	CPT Code	Days/Units
10/1/05	71020	3

- **CPT Modifier 77 – “Repeat procedure by another physician”:** A physician may need to indicate that he or she repeated a service performed by *another physician* on the same day.

Example:

Patient receives two EKGs on October 1, 2005. The first EKG is taken at 10:00 a.m. and Dr. A performs the interpretation. The second EKG is taken at 1:30 p.m. and Dr. B performs the interpretation.

Submit as:

Claim #1 – Dr. A

Date of Service	CPT Code	Days/Units
10/1/05	93010	1

Claim #2 – Dr. B

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	93010-77	1

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

Example:

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

Submit as:

Date of Service	CPT Code/CPT Modifier	Days/Units
10/1/05	82746	1
10/1/05	82746-91	1

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CMS Announces Outreach Conferences for Section 1011 (of the Medicare Modernization Act of 2003): Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

Provider Types Affected

Physicians, hospitals, including Medicare critical access hospitals, Indian Health Service facilities, and ambulance service providers treating patients eligible for payment of Section 1011 of the Medicare Modernization Act of 2003 (MMA).

Impact to You

You may be eligible for reimbursement for treating certain individuals under Section 1011 of the MMA. This article announces outreach sessions that will help you learn more about this program.

What You Need to Know

As of August 2006, over 15,500 physician and provider enrollment applications have been approved nationwide to participate in the Section 1011 reimbursement process. But, the Centers for Medicare & Medicaid Services (CMS) advises that funds remain available and you may be eligible.

What You Need to Do

CMS has scheduled two national outreach conferences to inform providers of their potential eligibility to participate and to provide more details. See the remainder of this article for details of these sessions and how this program may help you.

Background

Section 1011 of the MMA provides up to \$250 million per year for federal fiscal years 2005-2008 for payments to eligible providers for emergency services furnished to:

- Undocumented aliens;
- Aliens who have been paroled into a United States port of entry for the purpose of receiving eligible services; and
- Mexican citizens permitted to enter the United States on a laser visa, issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act.

The covered services are the same as those required by the Emergency Medical Treatment and Labor Act (EMTALA), as well as related hospital inpatient and outpatient services. Providers do not have to be enrolled in the Medicare program to receive Section 1011 eligibility and payments. However, you do have to enroll in the Section 1011 Program by submitting an application to TrailBlazer Health Enterprises, LLC, the national contractor for the Section 1011 Program.

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To provide you with more details about this program, Medicare, through TrailBlazer Health Enterprises, is offering two national outreach sessions for the medical community and the general public. Sessions are open to interested registrants in all states. The two sessions scheduled are as follows:

- September 26, 2006, from 8:30 a.m. - 12:30 p.m.
Camino Real Hotel El Paso
101 S. El Paso Street
El Paso, Texas 79901
- September 28, 2006, from 8:30 a.m. – 12:30 p.m.
Sheraton Newark Airport Hotel
128 Frontage Road
Newark, NJ 07114

These sessions will include an overview of Section 1011, as well as updates regarding Provider Enrollment, Medical Review, Payment Request Processing and Provider Education and Customer Service related to Section 1011. You may register for either session by going to TrailBlazer's Web site at <https://www.TrailBlazerhealth.com/Section1011/CalendarOfEvents/>.

Additional Information

Additional Information regarding the Section 1011 Program may be found on CMS' Web site at <http://www.cms.hhs.gov/UndocAliens>.

To learn more details, or to enroll as a provider, visit the TrailBlazer site at <http://www.TrailBlazerhealth.com/Section1011>. You may also reach TrailBlazer by telephone at 1-866-860-1011.

The September 28, 2006, session in Newark, NJ, will also be available via teleconference. In addition, at the above Web site, you will find information on a web-based training event scheduled for September 13.

Correct Coding Initiative (CCI) Edits, Version 12.3: Quarterly Update Effective October 1, 2006

Background

This article and related CR 5258 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on October 1, 2006. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) Web site. The Web site will be updated with the Version 12.3 edits as soon as they are effective.

Key Points

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, Version 12.3, is effective on October 1, 2006. This version will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table; and
- MEC Edits table.

Implementation

The implementation date for this instruction is October 2, 2006.

Additional Information

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS Web site.

Out-of-Balance Medicare Secondary Payer (MSP) Claims: Urgent Update

In prior notices regarding the non-acceptance of out-of-balance MSP claims, there were references and formulas provided for two separate levels of balance editing. One was at the claim level and the other was at the service line level. The Medicare Prepass edits assigned to these edits are M384 for claim level and M383 for service line level. The M383 edit has been turned off as the Centers for Medicare and Medicaid Services (CMS) has rescinded the requirement for MSP claims to balance at the service line level.

In order to be HIPAA compliant, effective September 29, 2006, Medicare will not accept out-of-balance claim level Medicare Secondary Payer (MSP) claims. This will be accomplished by setting the M384 edit to “Claim Delete”.

In the interim, out-of-balance MSP claims will continue to receive the M384 as an “Informational” error at the Batch Control Listing (BCL) pre-pass edit level if the primary paid amount (2320/AMT/D) and the adjusted amount(s) paid by the primary payer (2320/CAS or 2430/CAS) do not equal the billed amount (2300/CLM/02). Again, this Informational error will be changed to Claim Delete beginning September 29, 2006.

While Medicare may be able to handle such a balancing discrepancy because it does not currently use the information in the CAS segments for processing of MSP claims, the data may be passed to other payers. Other payers may then reject the claims because they do not comply with the *837 version 4010A1 Professional Implementation Guide*.

The following formula may be used to ensure an MSP claim meets the claim level balancing requirement:

The amount paid by the Primary Payer (Loop 2320/AMT/D02) plus any submitted claim level or line level adjustment amounts (Loop 2320 and/or Loop 2430 CAS03, 06,09, 12, 15, or 18) must be equal to the submitted charges (loop 2300/CLM02).

Our instructions for filing MSP claims electronically have been updated to reflect requirement changes and/or additions. These instructions may be found on our Web site at <http://www.PalmettoGBA.com/boh/Guide> (Ohio) or <http://www.PalmettoGBA.com/bwv/Guide> (West Virginia). Select Medicare Secondary Payer, Claims Filing Requirements, then Electronic Claims Submission. You may also refer to the “Shared Systems Medicare Secondary Payer (MSP) Balancing Edit and Administrative Simplification Compliance Act (ASCA) Enforcement Update” article published in the March 2006, *Medicare Advisory*, which is also located on our Web site. Select Publications, Medicare Advisories, 2006, and then the March 2006, *Medicare Advisory*.

If you have any questions, please contact the Ohio / West Virginia EDI Technical Support area at 1-866-308-5438.

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2007 Medicare Participation Enrollment Information

We are again excited to provide you with a CD-ROM packed full of useful information, which will include the 2007 Medicare Participation Enrollment form along with some valuable additional information. We anticipate that the CD-ROM will be mailed in November 2006 and will contain the following:

- Cover letter
- Fact Sheet
- Resource & contact listing
- CY 2007 Medicare Participation Enrollment announcement and agreement

Note: Fee schedule information for Ohio, South Carolina and West Virginia will only be available on our Web site at www.PalmettoGBA.com.

As a further bonus, the CD-ROM will contain a great deal of information that will not be available in the requested print version including:

- CMS 855 application information
- Electronic Data Interchange (EDI) information
- Electronic Funds Transfer (EFT) information
- Claim submission
- Deductible/co-insurance rates
- Much more!

We will distribute the information on a CD-ROM so that you will be able to:

- Print paper copies as needed
- View the portions that are applicable to your practice
- Copy information from computer to computer
- Store for easy retrieval

The CD-ROM should be readable by any system with Microsoft Windows or Macintosh OS 8 or greater. If you do not have a computer or if your computer lacks a CD-ROM drive, you can request a printed copy at no charge by returning the detachable post card that will accompany the CD-ROM.

Further information regarding the 2007 Participation Enrollment and Physician Fee Schedule may be available in future editions of the *Medicare Advisory* and on our Web site, www.PalmettoGBA.com.

You may also call the Palmetto GBA Provider Contact Center at 1-877-567-9232.

In addition, you can register to receive email notifications informing you when our Web site has been updated. This can be done by going to www.PalmettoGBA.com, clicking on [E-mail Updates](#) and following the instructions for registering.

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Drug/Radiopharmaceutical Not Otherwise Classified Codes National Drug Code Number to be Required “New Requirement”

Effective January 1, 2007, when a “not otherwise classified” or “unlisted” HCPCS procedure code is submitted, [J3490, J3590, J9999, A4641, A9699, and/or A9700], the National Drug Code (NDC) number **must be in block 19** or on an attachment to the CMS-1500 claim form. For electronic claims, this information must be provided in the documentation record.

The name and dosage is still required in block 19 of the CMS-1500 claim form or in the documentation record for electronic claims.

Services submitted without the NCD number and name & dosage will be rejected. Rejected claims do not have appeal rights and must be submitted as new claims.

Medicare Part B Drug Competitive Acquisition Program (CAP): Additions to Approved CAP Vendor's Drug List Effective October 1, 2006

Impact on Providers

This Special Edition article is being provided to inform physicians participating in the CAP program that, effective October 1, 2006, drugs are being added to the CAP drug table.

Background

The list of drugs supplied under the CAP is subject to quarterly updates, and this Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you of additions to the CAP drug list (Per Change Request (CR) 5079, Business Rules (BRs) 5079.3 and 5079.4. For more details, see the related *MLN Matters* article, MM5079 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf>.

Effective October 1, 2006, the CAP designated carrier will add the drugs listed in the following table to the CAP drug table, and the following Healthcare Common Procedure Coding System (HCPCS) codes will be available through the CAP:

HCPCS Code	Descriptor
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL (trade name Thyrogen®)
J9160	DENILEUKIN DIFTITOX, 300 MCG (trade name: Ontak®)
J9010	ALEMTUZUMAB, 10 MG (trade name Campath®)

An updated CAP drug list which includes the drugs listed above and updates to the NDC codes available through the CAP will be posted on the Approved CAP vendor page of the CMS CAP Web site (http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage) and on the approved CAP vendor's Web site (<http://www.bioscrip.com/>) on or about September 1, 2006.

Additional Information

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

Competitive Acquisition Program (CAP) - Creation of Automated Tables for Claims Received from Railroad Retirement Board Beneficiaries

Note: This article was revised on September 12, 2006, to reflect changes made to CR 5079. The CR release date, transmittal number (see above), and the Web address for accessing CR 5079 were changed. All other information remains the same.

Impact on Providers

This article is based on Change Request (CR) 5079, which provides additional information and instructions for the implementation of the CAP pertaining to CAP drug categories and fee schedule as outlined in CR 4064 (Transmittal 777, dated December 9, 2006).

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d); <http://www.cms.hhs.gov/MMAUpdate/>) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. The Social Security Act (Section 1847B(a)(1)(B); http://www.ssa.gov/OP_Home/ssact/title18/1847B.htm) states that for purposes of implementing the CAP:

“The Secretary (of the Department of Health and Human Services) shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate. ”

In addition, the Social Security Act also permits the creation of appropriate geographic regions established by the secretary for contract award purposes.

The Centers for Medicare & Medicaid Services (CMS) will implement the CAP with one category of drugs and one geographic area. However, as the program evolves, additional geographic areas and additional drug categories may be created. Also, approved CAP vendors will be able to request approval for changes to the lists of drugs that they supply under the CAP.

CR 4064 (Transmittal 777, dated December 9, 2006) described requirements for carriers to develop provider files that list physicians who have enrolled with an approved CAP vendor and the category (or categories) of drugs that the CAP vendor will furnish under the CAP.

CMS is issuing CR 5079 to automate the process of updating the list of drugs paid under the CAP. CR 5079 provides additional information and instructions for the implementation of the CAP pertaining to the CAP drug categories and fee schedule as outlined in:

- CR 4064 (Transmittal 777, dated December 9, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>; MLN Article MM 4064 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/____Continued on next page

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[MM4064.pdf](#)) and

- CR 4309 (Transmittal 866, dated February 6, 2006 (rescinded and replaced with transmittal 866 dated February 17, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf>); MLN article MM 4309 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>).

For the table defined in CR 4064.1.1.2.1, when Medicare carriers receive election forms from providers, the carriers will indicate for each provider:

- Which categories of drugs the provider has chosen to receive; and
- From which approved CAP vendor the provider will receive CAP drugs

CAP Drugs and Drug Categories

Approved CAP vendors will be permitted to request certain changes to the list of drugs that they supply under the CAP. Beginning in July 2006 with changes to be effective October 1, 2006, approved CAP vendors may request that CMS (or its designee) approve the following types of changes:

- **NDC Substitution(s):** Approved CAP vendor may request approval to replace one or more National Drug Codes (NDCs) in a Healthcare Common Procedure Coding System (HCPCS) code supplied by the approved CAP vendor with one or more other NDCs.
- **NDC Addition(s):** Approved CAP vendor may request that CMS allow it to supply additional NDCs under a HCPCS code that the approved CAP vendor already supplies under the CAP.
- **HCPCS Addition(s):** Approved CAP vendor may request that CMS allow it to supply newly issued HCPCS codes under the CAP.
- **Orphan Drugs:** Approved CAP vendor may request that CMS allow it to supply single indication orphan drugs under the CAP.

As CMS continues to develop the CAP, additional geographical areas and additional drug categories may be created. If additional drug categories are created, certain drugs may appear in more than one drug category.

Changes to the Drug List

Written requests for changes to the approved CAP vendor's drug list must be submitted to CMS and the CAP designated carrier. The requests must include a rationale for the proposed change, and a discussion of the impact on the CAP, including safety, waste, and potential for cost savings. If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS Web site (<http://www.cms.hhs.gov/competitiveacqisforbios/>) and notify the carriers and participating CAP physicians of any changes on a quarterly basis.

Participating CAP physicians will be notified of changes to their approved CAP vendor's CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. Physicians who participate in the CAP are required to obtain all CAP drugs, including those that have been added or otherwise updated, from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor. Please note that approved changes will apply only to the list of drugs supplied

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by the approved CAP vendor who submitted the request; therefore, each vendor's drug list may contain different drugs after changes to the initial drug list are approved.

Payment Amount

The payment amount for new HCPCS codes added to an approved CAP drug vendor's drug list will be Average Sales Price (ASP) plus six percent (ASP+ 6%).

Addition or substitution of NDC numbers under an existing HCPCS code supplied by an approved CAP vendor will not change the CAP single payment amount for that HCPCS code.

CMS will update the single payment amount based on the approved CAP vendor's reported net acquisition costs for the category of drugs on an annual basis.

Disaster Contingency

Business requirements intended to cover situations where an approved CAP vendor is not able to fill CAP orders or is no longer able to supply drugs under the CAP have also been added. Physicians will be able to revert to the ASP (buy and bill) payment methodology.

Claims for Railroad Retirement Board (RRB) Beneficiaries

As claims for RRB beneficiaries can not be paid under the CAP, physicians should not order drugs for RRB beneficiaries under the program. However, should this occur, and the claim is sent to the carrier that processes claims for RRB beneficiaries, that carrier will treat the claim as unprocessable. The physician will have to resubmit the claim as a non-CAP claim with the drugs billed as ASP. The vendor will then have to look to the physician for reimbursement of the drugs that were mistakenly ordered under CAP.

Implementation

The implementation date for the instruction is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1055CP.pdf>.

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

Transitional Use of Medicare Part B Drug Competitive Acquisition Program (CAP) Resupply Option and the J2 HCPCS Modifier

Provider Types Affected

Physicians participating in the CAP program who have submitted claims to Medicare carriers for services related to the emergency administration of Part B drugs to Medicare beneficiaries in their office.

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) discovered that during CAP implementation, certain situations arose where participating CAP physicians may have 1) administered drugs to Medicare beneficiaries from their office stock in situations that may not have met the required criteria, and 2) sought a replacement drug product through the use of the J2 restocking HCPCS modifier.

CAUTION – What You Need to Know

Until September 30, 2006, CAP participating physicians who submitted claims for CAP drugs under the ASP (buy and bill) system may request that these claims be reopened and reprocessed as a CAP claim if the claims are submitted with the appropriate CAP information and the J2 HCPCS modifier.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) established the Competitive Acquisition Program (CAP) to offer physicians who administer Part B drugs to Medicare beneficiaries in their offices the option of obtaining many of these drugs under the CAP starting on January 1, 2006. Additional background information on the CAP can be found on CMS' Web site at <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>.

Physicians are required to obtain all drugs on the CAP drug list from an approved CAP vendor. However, in certain circumstances the physician may administer a drug from his/her office stock using the 'J2' restocking HCPCS modifier if (in the physician's clinical judgment) the conditions stated in business requirement (BR) 4064.5 are met (To view full details of CR 4064, see its related *MLN Matters* article, MM 4064, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>.)

CMS discovered that during CAP implementation, certain situations arose where participating CAP physicians may have 1) administered drugs to Medicare beneficiaries from their office stock in situations that may not have met the criteria listed in BR4064.5, and 2) sought a replacement drug product through the use of the 'J2' restocking HCPCS modifier.

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Many of these situations 1) arose during the CAP physicians' transition from the ASP (buy and bill) system to the CAP, and 2) were related to delays and other procedural issues encountered during the physician election process.

Prior to September 30, 2006

During the next several weeks, CMS advises CAP participating physicians who have had ASP claims for CAP drugs denied that they may request that their claims be reopened and reprocessed as a CAP claim if the claims are submitted with the appropriate CAP information and the J2 HCPCS modifier.

After September 30, 2006

CMS expects the CAP resupply option to be used only in situations that meet the criteria described in BR 4064.5.

Additional Information

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

X12 Implementation Guides Adopted as HIPAA Standards from Washington Publishing Company (WPC): Revision to Chapters 22 & 24 to Delete References to Free Downloads

Background

The Centers for Medicare & Medicaid Services (CMS) had funded WPC to allow the implementation guides adopted as Health Insurance Portability and Accountability Act (HIPAA) standards to be downloaded without charge to facilitate implementation. Covered entities have had more than 3 years to download the guides. CMS will no longer fund free downloads of the version 4010A1 guides.

Key Points

This article and Change Request (CR) 5247 includes clarifications that apply to sections and/or subsections in these chapters that refer to free Implementation Guides (IG's) from Washington Publishing Company (WPC). References regarding "free IG's" are being deleted from the *Medicare Claims Processing Manual*.

- Any references on the WPC Web site(s) to free HIPAA implementation guides from <http://www.wpc-edi.com/HIPAA> will be modified to note that there is now a fee.
- Covered entities will still be able to order guides from WPC at the above URL, but for a fee.

Implementation

The implementation date for CR5247 is November 20, 2006

Additional Information

For complete details, please see the official instruction issued to your Medicare carrier, FI, RHHI, or DMERC regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1033CP.pdf>.

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

Remittance Advice: Are You Receiving Yours?

Beginning June 1, 2006, carriers and DMERCs stopped sending standard paper remittance (SPR) advices to you (or a billing agent, clearinghouse, or other entity representing you) if you have been receiving electronic remittance advice (ERA) transactions (also called 835 transactions), either directly or through a billing agent, clearinghouse, or other entity representing you, for 45 days or more.

If you work with a clearinghouse to submit electronic claims:

- Does the clearinghouse forward ERAs to you? If not, verify with the clearinghouse if you have an agreement with them regarding ERAs.
- If your clearinghouse is receiving your ERAs, you may need to establish a separate agreement with the clearinghouse in order for you to receive them.
- If you are unable to obtain your ERAs from the clearinghouse, you may still arrange to receive your ERAs directly from Medicare.
- Once you have made an arrangement to receive your ERAs through a clearinghouse, billing agent or directly from Medicare you are eligible to receive free software through Palmetto GBA to view your ERAs. Download the Medicare Remit Easy Print (MREP) software from our Web site:
 - Ohio: www.PalmettoGBA.com/boh/EDI
 - West Virginia: www.PalmettoGBA.com/bwv/EDI
- Your clearinghouse may also offer software that allows you to view and print your remittance advice.

Benefits of MREP software

- The benefits of using MREP software include the ability to:
 - Print paper remittances and reports to reconcile accounts receivable
 - Print notices for a single patient for submission to secondary payers (no need to black out information for other patients)
 - Print notices directly from your computer the same day that the electronic file becomes available to you – no more time is spent waiting for the mail
 - Print special reports:
 - Deductible Service Lines Report: Shows claim service lines that have deductible amount.
 - Adjusted Service Lines Report: Shows claims within a single remittance that have a claim status 22 (reversed claim).
 - Denied Service Lines Report: Shows only claim service lines that have an allowed amount of zero and are associated with a claim that does not have a claim status 22 (reversed claim).
 - Search remittance notices by HIC, account number, procedure code, date of service, and provider number

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- Save money and space for physical storage of paper documents, by saving them electronically with MREP

For more information on MREP software:

- Call the EDI Technical Support Line at **1-866-308-5438**. We are experienced with this software and we will be happy to assist with any questions you have.
- If you are currently receiving paper remittance notices (SPRs), MREP software can help you manage your Medicare business. Call us and we will help you get started!

Other Resources

- *MLN Matters* article #MM4347 contains additional information regarding the transition from paper to electronic remittance notices. Read the complete article at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf>.
- Access the CMS Web site for additional resources related to electronic data interchange: <http://www.cms.hhs.gov/ElectronicBillingEDITrans/>.

October 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2006, and Revisions to January 2006, April 2006 and July 2006 Quarterly ASP Medicare Part B Drug Pricing Files

Note: This article was revised on September 25, 2006, to reflect changes to CR 5270, which CMS re-issued on September 22, 2006. The article was revised, as was CR 5270, to remove references to the revised January 2006 file. The CR transmittal number, release date, and Web address for accessing CR 5270 were also changed. All other information remains the same.

Provider Action Needed

Impact to You

Change Request (CR) 5270, upon which this article is based, provides notice of the updated payment allowance limits effective October 1, 2006, and revisions to the January 2006, April 2006, and July 2006 quarterly drug pricing files.

What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

What You Need to Do

Make certain that your billing staffs are aware of these changes.

Background

CR 5270, upon which this article is based, provides the quarterly average sales price (ASP) Medicare Part B drug pricing file update for October 1, 2006, and also provides revisions to the January 2006, April 2006 and July 2006 quarterly files.

Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis; and mandated that since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis be paid based on the average sales price (ASP) methodology.

In the same way in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities; specified, covered outpatient drugs; and drugs and biologicals with pass-through status under the OPPS will be paid according to this ASP methodology, which is based on quarterly data submitted to CMS by manufacturers.

Note that MMA also requires CMS to update the payment allowance limits quarterly, which CR 5270 does.

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Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis have been paid based on **106%** of the average sales price (ASP). Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS, will be paid based on **106%** of the ASP.

There are exceptions to this general rule as summarized below.

1. Blood and Blood Products

Blood and blood products furnished in the hospital outpatient department are paid under the outpatient prospective payment system (OPSS) at the amount specified for the APC to which the product is assigned. Conversely, for blood and blood products, not paid on a prospective payment basis (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner used to determine them on October 1, 2003.

The payment allowance limits for blood and blood products are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia. These payment allowance limits will be updated on a quarterly basis, along with the others.

2. Infusion Drugs

The 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% of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits were not updated in 2006. The payment allowance limits for infusion drugs (unless compounded), 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% of the first published AWP.

3. Influenza, Pneumococcal and Hepatitis B vaccines

The payment allowance limits for Influenza, Pneumococcal and Hepatitis B vaccines are 95% of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. In this latter instance, the vaccine is paid at reasonable cost.

4. Drugs not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File

The payment allowance limits for drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing.

In determining the payment limit based on WAC, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) follow the methodology in the *Medicare Claims Processing Manual* specified

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for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals at <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS Web site.)

The payment limit is 100% of the lesser of the lowest brand or median generic WAC. And note that for 2006, when the blood clotting factor is not included on the ASP file, the blood clotting furnishing factor of \$0.146 per I.U. is added to the blood clotting factor payment amount.

Your Medicare contractor may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting contractor or will post them in an MS Excel file on the CMS Web site. If the payment limit is available from CMS, contractors will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

1. New Drugs

The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106% of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005. As mentioned above, for 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file.

2. Radiopharmaceuticals

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio. And your carrier/FI will determine payment limits for radiopharmaceuticals not furnished in the hospital outpatient department based on the methodology in place as of November 2003.

3. Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

CR 5270 clarifies that 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. Your carrier or FI will develop the pricing for compounded drugs.

Physicians (or a practitioner described in Section 1842(b)(18)(C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for them to perform the service. Your carrier/FI must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for: 1) The professional service of filling or refilling the implantable pump or reservoir; and 2) For drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if: 1) The medication administered is accepted as a safe and effective treatment of the patient's illness or injury; 2) There is a medical reason that the medication cannot be taken orally; and 3) The nurse's skills are needed to infuse the medication safely and effectively.

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Here are some important things you should remember.

- The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.
- Pricing for compounded drugs is performed by your carrier/FI.
- The presence or absence 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 will make these determinations.
- The October 2006 and revised January 2006, April 2006 and July 2006 ASP drug pricing files for Medicare Part B drugs will be available via the CMS Data Center (CDC) for your carriers/FIs to download on or after September 19, 2006.
- You can also view the October 2006 and revised January 2006, April 2006, and July 2006 ASP NOC drug pricing files for Medicare Part B drugs (on or after September 22, 2006) at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage on the CMS Web site.

Note that:

- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006 through June 30, 2006;
- The revised July 2006 payment allowance limits apply to dates of service July 1, 2006 through September 30, 2006; and
- The October 2006 payment allowance limits apply to dates of service October 1, 2006 through December 31, 2006.

Additional Information

You can find the official instructions issued to your carrier/FI/RHHI/DMERC regarding this change by going to CR 5270, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1066CP.pdf> on the CMS Web site.

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

Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS): October 2006 Quarterly Update

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment (DME) regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS Fee Schedule.

Background

This article and related CR 5255 provide specific information regarding the quarterly update for the October 2006 DMEPOS Fee Schedule.

Key Points

Quarterly Update

The DMEPOS fee schedules are updated on a quarterly basis to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Required Payment

Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Codes Added to HCPCS

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2006, and are effective for claims with dates of service on or after October 1, 2006:

- HCPCS code K0738 (Portable Gaseous Oxygen System, Rental; Home Compressor Used To Fill Portable Oxygen Cylinders; Includes Portable Containers, Regulator, Flow meter, Humidifier, Cannula Or Mask, And Tubing) This code is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.
- HCPCS codes K0800 through K0802, K0806 through K0808, K0812 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, K0898 and K0899, as appropriate, for related Power Mobility Device claims.

The descriptions for these codes and other codes in this article may be found in CR 5255 at <http://www.cms.hhs.gov/Transmittals/downloads/R1037.pdf> on the CMS Web site.

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For power wheelchairs furnished on a rental basis with dates of service prior to October 1, 2006, use HCPCS codes K0010, K0011, K0012, and K0014 as appropriate.

Claims for HCPCS codes K0010, K0011, K0012 and K0014 with dates of service on or after October 1, 2006, if the claims are for purchase of initial rental of the item, will be rejected.

The fee schedules for HCPCS code E1238 (Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System) are being revised as part of this update to correct errors in calculation and are effective for dates of service on or after January 1, 2006.

Fee schedule amounts for HCPCS codes E2620 and E2621 are being revised to correct fee schedule assignment errors for claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code A7043 (Vacuum drainage bottle and tubing for use with implanted catheter) are being revised as part of this update to correct calculation errors and will be effective for dates of service on or after January 1, 2006.

Previously processed claims for HCPCS codes E2620, E2621, A7043 and E1238 with dates of service on or after January 1, 2006, will be adjusted if they are resubmitted as adjustments.

The fee schedule for HCPCS code L8689 (External recharging system for implanted neurostimulator, replacement only) was revised. FIs and carriers will adjust previously processed claims for HCPCS code L8689 with dates of service on or after January 1, 2006, if they are resubmitted as adjustments.

HCPCS code L8689 should only be used for external systems that recharge implanted batteries (i.e., external recharging of batteries that area inside the patient). Claims for replacements for other types of implanted neurostimulator battery charging systems should be submitted using HCPCS code L8699.)

The fee schedules for HCPCS code L2232 (Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only) are added to the fee schedule file on October 1, 2006, and are effective for new claims with dates of service on or after January 1, 2005.

HCPCS code H0049 (Alcohol And/Or Drug Screening) and HCPCS code H0050 (Alcohol And/Or Drug Services, Brief Intervention, Per 15 Minutes) are being added to the HCPCS on June 30, 2006, and will be available on January 1, 2007, for assignment by insurers in accordance with their programs and policies.

Effective October 1, 2006, for services performed on or after January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) have made a revision in the reimbursement for HCPCS codes A7043 and L8689.

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Revision in Reimbursement:

Effective October 1, 2006, for services performed on or after January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) have made a revision in the reimbursement for HCPCS codes A7043 and L8689.

HCPCS Codes	State	Current Amount	Revised Amount
A7043	Ohio	\$23.72	\$26.88
	West Virginia	\$29.22	\$26.24
L8689	Ohio	\$33.54	\$1391.39
	West Virginia	\$32.74	\$1358.04

Note: HCPCS code L8689 should only be used for external systems that recharge implanted batteries (i.e., external recharging of batteries that are inside the patient). Claims for replacements for other types of implanted neurostimulator battery charging systems should be submitted using L8699.

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

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

Implementation

The implementation date for the instruction is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your Medicare carrier, FI, RHHI, DMERC, or DME/MAC regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1037CP.pdf> on the CMS Web site.

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

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Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment: Manualization

Note: This article was revised on August 28, 2006, to reflect revisions made to CR 5105, which CMS released on August 25, 2006. The Transmittal number, CR release date, and Web address for accessing CR 5105 have been changed. All other information remains the same.

Impact on Providers

This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR 5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a Managed Care Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

Background

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in a MA Organization, the MA Organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

Overview of the MA plan Enrollment Process

When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the managed care plan enrollment period are identified by Medicare's Common Working File (CWF); and
- An Informational Unsolicited Response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the managed care plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR 2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted; and
- Medicare contractors will initiate overpayment recovery procedures.

Note: CR 2801 (Transmittal AB-03-101, dated July 18, 2003) can be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf>.

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Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see *MLN Matters* article, SE 0638, which is available on CMS' Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf>.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the managed care plan for payment.

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
 - That the beneficiary was in a managed care plan on the date of service;
 - That the provider should bill the managed care plan;
 - What the plan identification number is; and
 - Where to find the plan name and address associated with the plan number on the CMS Web site.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, go to CMS' Web site at http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage.

In summary, CMS issued CR 5105 to:

- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and
- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Publication 100-06, Chapter 3, Section 190), which is included as part of CR5105. Instructions for accessing CR 5105 are in the *Additional Information* section of this article.

Implementation

The implementation date for the instruction is June 26, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R106FM.pdf>. If you have any questions, please contact our office at 1-877-567-9232.

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Diabetes Screening Tests: Medicare Provides Coverage for Eligible Medicare Beneficiaries

Provider Action Needed

This article serves as a reminder that Medicare provides coverage of diabetes screening tests for eligible Medicare beneficiaries. We need your help in ensuring that Medicare beneficiaries are assessed for and informed about their risks factors for diabetes or pre-diabetes, and that those who are eligible take full advantage of the Medicare diabetes screening benefit.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) expanded preventive services covered by Medicare to include diabetes screening tests, effective for services provided on or after January 1, 2005, for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes.

The information in this Special Edition MLN Matters article reminds health care professionals about the coverage; eligibility, frequency, and coding guidelines for diabetes screening tests so that you can talk with your Medicare patients about this preventive benefit and file claims properly for the screening service.

Tests Included

Coverage includes the following diabetes screening tests:

- A fasting blood glucose test, **and**
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults), **OR**
- A 2-hour post-glucose challenge test alone.

Note: Other diabetes screening blood tests for which the Centers for Medicare & Medicaid Services has not specifically indicated national coverage continue to be non-covered.

Eligibility

Medicare beneficiaries who have any of the following risk factors for diabetes are eligible for this screening benefit:

- Hypertension;
- Dyslipidemia;
- Obesity (a body mass index equal to or greater than 30 kg/m²); or
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

OR

Medicare beneficiaries who have a risk factor consisting of at least two of the following characteristics are eligible for this screening benefit:

- Overweight (a body mass index > 25, but < 30 kg/m²);
- A family history of diabetes;

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- Age 65 years or older;
- A history of gestational diabetes mellitus, or delivering a baby weighing > 9 pounds.

Note: No coverage is permitted under the MMA benefit for beneficiaries previously diagnosed with diabetes since these individuals do not require screening.

Frequency

- Beneficiaries diagnosed with pre-diabetes:
- Medicare provides coverage for two diabetes screening tests per year (once every six months) for beneficiaries diagnosed with pre-diabetes.
- Beneficiaries not previously diagnosed with pre-diabetes:
- Medicare provides coverage for one screening per year for beneficiaries who were previously tested who were not diagnosed with pre-diabetes, or who have never been tested.

Note: The Medicare beneficiary must be provided with a referral by a physician or qualified non-physician practitioner for the diabetes screening test (s).

Claim Filing Information

The following Healthcare Common Procedure Coding System (HCPCS) codes, diagnosis code, and modifier must be used when filing claims for diabetes screening tests:

HCPCS Codes	Code Descriptors
82947	Glucose; quantitative, blood (except reagent strip)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)
Diagnosis Code: V77.1	<p>To indicate that the purpose of the test(s) is for diabetes screening for a beneficiary that <i>does not</i> meet the *definition of pre-diabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim.</p> <p>To indicate that the purpose of the test (s) is for diabetes screening for a beneficiary that meets the *definition of pre-diabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim and modifier “TS” (follow-up service) is to be reported on the line item.</p>

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*Definitions

Diabetes: Diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a two-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Pre-diabetes: Abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a two-hour post-glucose challenge of 140 to 199 mg/dL. The term “pre-diabetes” includes impaired fasting glucose and impaired glucose tolerance.

Payment for Diabetes Screening Tests

Medicare will pay for diabetes screening tests under the Medicare Clinical Laboratory Fee Schedule. Medicare beneficiaries can receive the diabetes screening test at no cost to them. There is no coinsurance, co-payment, or deductible for this benefit.

For More Information

For more information about Medicare’s diabetes screening benefit, visit the CMS Diabetes Screening Web page on CMS Web site at <http://www.cms.hhs.gov/DiabetesScreening/>.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff becomes familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare:

- The MLN Preventive Services Educational Products Web Page provides descriptions and ordering information for all provider specific educational products related to preventive services. The CMS Web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.
- The CMS web site provides information for each preventive service covered by Medicare. Visit <http://www.cms.hhs.gov> select “Medicare,” and scroll down to “Prevention.”

For products to share with your Medicare patients, visit <http://www.medicare.gov> on the Web.

Medicare beneficiaries can obtain information about Medicare preventive benefits at <http://www.medicare.gov> and then click on “Preventive Services”. They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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“Frequently Asked Questions... Answered for You!”

1. Can you tell where to find information that would list the CPT codes and corresponding required level of physician supervision for diagnostic testing?

Answer: The best source of information on the required level of supervision is the CMS Web site. To access the supervision database, go to <http://www.cms.hhs.gov/apps/pfslookup/step0.asp>. Select “all fields” for complete information.

Additional information regarding physician supervision services for diagnostic testing can be found at CMS Web site: www.cms.hhs.gov/manuals and clicking on the following:

- Internet-Only Manuals (IOMs)
- Publication # 100-02, “Medicare Benefit Policy Manual”
- Chapter 15, “Covered Medical and Other Health Services”
- Section 80, “Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests”

2. If a patient is seen for the first time for a consult for a long-standing condition such as diabetes, would the problem be scored as a new diagnosis/problem or an established diagnosis/problem?

Answer: The term “new problem” is one that is identified, yet undiagnosed and may or may not require an additional work-up. A patient presenting to a new provider with a diagnosed problem is scored the same as presentation to a provider familiar with that patient’s problem. Therefore, for the purpose of scoring Evaluation & Management documentation, a new problem is one that is new to the patient, not to the provider. For further information please visit us on the Web at:

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

- Select Resources, then FAQs
- Medical Review
- E/M Services Frequently Asked Questions...Answered for You, Medical Review, May 2005

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Free Evaluation & Management Medicare Part B Seminars

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

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

Ohio Seminars

Date	Location	Time
Wednesday, November 8, 2006	Veterans' Memorial Civic & Convention Center of Lima/Allen County 7 Town Square Lima, Ohio 45801	9:00 a.m. - 12:00 p.m.
Wednesday, February 7, 2007	Best Western Columbus North 888 E. Dublin Granville Road Columbus, Ohio 43229	9:00 a.m. – 12:00 p.m.
Wednesday, May 16, 2007	Holiday Inn 5513 Milan Rd. Sandusky, Ohio 44870	9:00 a.m. – 12:00 p.m.
Wednesday, August 1, 2007	Holiday Inn/Muskingum Valley Conference Center 4645 East Pike Zanesville, Ohio 43701	9:00 a.m. – 12:00 p.m.

West Virginia Seminars

Date	Location	Time
Wednesday, November 29, 2006	The Serbian-American Cultural Center 100 Colliers Way Weirton, WV 26062	9:00 a.m. - 12:00 p.m.
Wednesday, May 30, 2007	Brier Inn 540 N. Jefferson St. Lewisburg, WV	9:00 a.m. - 12:00 p.m.
Wednesday, August 29, 2007	Clarion Hotel & Conference Center 233 Lowe Drive Shepherdstown, WV 25443	9:00 a.m. - 12:00 p.m..

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Registration:

To Register for a seminar please go to:

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

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

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

Paravertebral Facet Joint Block: Coding Guidelines

The following coding guidelines should be used in conjunction with the Paravertebral Facet Joint Block LCD.

CPT codes 64470 - 64476

- **CPT codes 64470 or 64475** must be used to bill for the first vertebral level blocked.
 - Only one unit of **CPT code 64470 or 64475** may be submitted for a date of service.
 - Use **CPT modifier 50** (bilateral procedure) with the appropriate CPT code(s) for any level to denote that bilateral blocks were performed at that level.
- **CPT codes 64472 or 64476** are add-on codes that are billed in addition to CPT codes 64470 or 64475.
 - Up to two units of **CPT code 64472 or 64476** may be billed for a date of service.
- **CPT codes 64470 – 64476** must not be used for local anesthesia during surgical procedures. Local anesthesia by the surgeon is included in the surgical procedure.
- Only one unit per CPT code is allowed regardless of the number of pharmacologic agents injected at the same site; e.g., steroids and anesthetics.
- **HCPCS modifier -LT (left) or -RT (right) MUST** be used with the appropriate CPT code(s) for any level to denote that **UNILATERAL** blocks were performed at that level.
- **CPT code 76005** is submitted for fluoroscopic guidance and localization of needle placement performed in conjunction with **CPT codes 64470 – 64476**.
- Injecting any substance through the needles including small amounts of contrast to confirm the position of the needle is an integral part of the procedure and it is not reimbursed separately.
- When destruction of the facet joint nerve is performed on the same date of service following the block, only the code for nerve destruction will be allowed. The facet nerve block procedure is included in the facet nerve destruction.

Bilateral Blocks

- CPT modifier 50 (bilateral procedure) **MUST** be included with the appropriate CPT code(s) for any level to denote that **BILATERAL** blocks were performed at that level.

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Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty (PTA) Concurrent with the Placement of an FDA-approved Carotid Stent

Note: This article was revised on August 28, 2006, to reflect changes made to CR 5022, which CMS re-issued on August 25. The transmittal number, CR release date, and Web address for accessing CR 5022 were changed. All other information remains the same.

Key Points

- This article is based on CR 5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities “approved facilities” Web site link in Publication 100-03, *The National Coverage Determinations Manual*. The list is now available at <http://www.cms.hhs.gov/MedicareApprovedFacilities/CASF/list.asp>.
- Claims that are being billed for Category B IDE studies and post-approval studies, per CR 1660 (effective July 1, 2001) and CR 3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR 3811 (effective March 17, 2005). The links to CR 1660 and the Medicare Learning Network (MLN) articles relating to CR 3489 and CR 3811 can be found in the *Related Links* section below.
- CMS created a new section in the *Medicare Claims Processing Manual* specific to carotid stents. Please refer to this new section in the manual attachment to CR 5022, (Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 32, Sections 160.1-160.3) for more information about PTA for implanting the carotid stent. (This includes information on CR 660, CR 3489 and CR 3811.)

Background

Percutaneous Transluminal Angioplasty (PTA) involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of PTA is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased and embolization is decreased. With the development and use of balloon angioplasty for treatment of atherosclerotic and other vascular stenoses, PTA (with and without the placement of a stent) is a widely used technique for dilating lesions of peripheral, renal, and coronary arteries.

Please refer to the manual attachment to CR 5022, Transmittal 53, (Publication 100-03, *The Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 20.7) for more information about the nationally covered indications for PTA concurrent with carotid stent placement, and for facilities accepted for services related to CAS with embolic protection. This is available at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf>.

Category B IDE Study Claims and Post-approval Study Claims

Effective for dates of service on or after March 17, 2005, the following claims are not subject to the approved facility list. These are CAS claims:

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- Billed under a Category B IDE study (identified by a six-digit IDE number preceded by a “G,” i.e., G123456); or a
- Billed under an FDA-approved post-approval study (identified by a six-digit PMA number preceded by a “P,” i.e., P123456)
- Previously denied due to the unintended application of the “approved” facility edit created per CR 3811 that are brought to your FI’s or carrier’s attention will be adjusted (per CR 1660 for Category B IDE Study Claims, and CR 3489 for Post-approval Study Claims).

CAS with Embolic Protection Claims

- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims will be paid only if they are from facilities listed on the approved list (see <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp>).

CAS with embolic protection claims from non-approved facilities will be rejected rather than denied. (CR 3811)

- Effective for dates of service on or after March 17, 2005, CAS **with** embolic protection claims that contain CPT 37216 (transcatheter placement of intravascular stent(s) without distal embolic protection) will **not** be paid. CMS has deemed CPT code 37216 a non covered service for Medicare purposes.

Related Links

CR 1660, *Claims Processing Instructions for Clinical Trials on Carotid Stenting With Category B Investigational Device Exemptions (IDEs)* can be found at <http://www.cms.hhs.gov/Transmittals/Downloads/AB0174.pdf>.

MM 3489, *Percutaneous Transluminal Angioplasty (PTA)* can be found at the following link <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf>.

MM 3811, *Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA)* is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf>.

CR 5022 is the official instruction issued to your carrier regarding changes mentioned in this article, MM 5022. CR 5022 may be found by going to Transmittal 911CP at <http://www.cms.hhs.gov/Transmittals/downloads/R1042CP.pdf> for the claims processing instructions and to Transmittal 53NCD for the NCD Manual section, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf> on the CMS Web site.

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

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Independent Diagnostic Testing Facilities (IDTF) Billing Information

When submitting claims for services rendered, IDTF's must indicate their Provider Identification Number (PIN) as the "billing provider" and should not enter a "performing provider" on the service line.

Electronic Claim Submission Using the ANSI 4010A1 Format:

The PIN for the IDTF should be indicated in:

- Loop: 2010AA,
- Segment: REF/1C,
- Element: 02

Claims Submitted Using the CMS-1500 Claim Form:

- The IDTF's name, address, zip code, and PIN are required in Item 33.

Services may be rejected when:

- The IDTF PIN is not indicated as required,
- A "performing provider" is indicated on the service line.

Rejected claims must be resubmitted as new claims and not as redeterminations.

CLIA Update

Listed below are the latest tests approved by the Food and Drug Administration as waived under CLIA, effective October 2, 2006.

CPT Code/HCPCS Modifier & Test Name	Manufacturer	Use
80101QW – First Check Diagnostics LLC, First Check Home Drug Test Marijuana	Acon Laboratories, Inc.	Screening test for the presence/detection of cannabinoids (THC) in urine
82274QW & G0328QW – ImmoCare Fecal Occult Blood Test	Care Diagnostics, Inc.	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening) by immunoassay
87804QW – BinaxNOW Influenza A & B Test {Nasopharyngeal (Np) Swab and Nasal Wash/Aspirate Specimens} K053126	Binax, Inc.	Qualitative detection of influenza type A & B antigens from nasal swab, nasal wash or nasal aspirate specimens that does differentiate between influenza types A & B
87899QW – Meridian Bioscience Immunocard STAT! HpSA {Stool}	Meridian Bioscience, Inc.	Immunoassay for the qualitative detection of <i>Helicobacter pylori</i> antigens in stool specimens

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Laboratory Competitive Bidding Demonstration

Provider Types Affected

Physicians and all providers who bill Medicare carriers and fiscal intermediaries (FIs) for laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and Change Request (CR) 5205 provides instructions for the implementation of a laboratory competitive bidding demonstration. CR 5205 is being implemented in multiple phases. The requirements specified in this article and CR 5205 is in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore **exempt** from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing **are not included in the demonstration, except** where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for “demonstration tests” provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as “required bidders.”

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Passive Laboratories

Small laboratories or laboratory firms with less than \$100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will **not be required** to bid in the demonstration. These laboratories are considered “passive” laboratories.” Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of \$100,000.

Passive laboratory firms exceeding the annual ceiling of \$100,000 will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled “winners.”

Non-Winners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled “non-winners.”

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

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Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5205 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

By January 1, 2007, CMS will provide Medicare carriers and fiscal intermediaries (FIs) with a national zip code pricing file identifying the zip codes included in the first CBA. Also, by the same date, CMS will provide to the carriers/FIs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

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Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (non-covered charges);
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.*); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a CPT modifier 90 submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim. A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

The demonstration in the first CBA is scheduled to begin on April 1, 2007 and the tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is January 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier/FI regarding this change can be found on CMS' Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R49DEMO.pdf>.

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

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Laboratory National Coverage Determination (NCD) Edit Software: Changes for October 2006

Impact on Providers

This article is based on Change Request (CR) 5293, which announces the changes that will be included in the October 2006 release of the edit module for clinical diagnostic laboratory services.

Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its shared systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective January 1, 2003. The 23 national coverage determinations are listed below:

1. Culture, Bacterial, Urine
2. Human Immunodeficiency Virus Testing (Prognosis including monitoring)
3. Human Immunodeficiency Virus Testing (Diagnosis)
4. Blood Counts
5. Partial Thromboplastin Time
6. Prothrombin Time
7. Serum Iron Studies
8. Collagen Crosslinks, Any Method
9. Blood Glucose Testing
10. Glycated Hemoglobin/Glycated Protein
11. Thyroid Testing
12. Lipids
13. Digoxin Therapeutic Drug Assay
14. Alpha-fetoprotein
15. Carcinoembryonic Antigen
16. Human Chorionic Gonadotropin
17. Tumor Antigen by Immunoassay - CA125
18. Tumor Antigen by Immunoassay CA 15-3/CA 27.29
19. Tumor Antigen by Immunoassay CA 19-9
20. Prostate Specific Antigen
21. Gamma Glutamyl Transferase
22. Hepatitis Panel/Acute Hepatitis Panel
23. Fecal Occult Blood

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub.100-4), Chapter 16, §120.2, <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf>).

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CR 5293 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for October, 2006, that require updating of the laboratory edit module. These changes become effective for services furnished on or after October 1, 2006.

Changes are being made to the NCD code lists for services furnished on or after October 1, 2006, are as follows:

190.12 - Urine Culture, Bacterial

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD:

- ICD-9-CM codes 288.00, 288.01, 288.02, 288.03, 288.04, 288.09, 608.20, 608.21, 608.22, 608.23, 608.24, 616.81, 616.89, 780.96, 780.97, 788.64 and 788.65.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD:

- ICD-9-CM codes 288.0, 608.2 and 616.8.

190.14 - Human Immunodeficiency Virus (HIV) Testing (Diagnosis)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14) NCD:

- ICD-9-CM codes 052.2, 053.14, 054.74, 288.00, 288.01, 288.02, 288.03, 288.04, 288.09, 288.4, 288.50, 288.51, 288.59, 288.60, 288.61, 288.62, 288.63, 288.64, 288.65, 288.69, 289.53 and 331.83.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14) NCD:

- ICD-9-CM code 288.0.

190.15 - Blood Counts

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes that do not support medical necessity for the Blood Counts (190.15) NCD:

- ICD-9-CM codes 338.0, 338.11, 338.12, 338.18, 338.19, 338.21, 338.22, 338.28, 338.29, 338.4, 389.15, 389.16, 478.11, 478.19, 521.81, 521.89, 525.60, 525.61, 525.62, 525.63, 525.64, 525.65, 525.66, 525.67, 525.69, 526.61, 526.62, 526.63, 526.69, 608.20, 608.21, 608.22, 608.23, 608.24, 618.84, V26.34, V26.35, V45.86, V72.11 and V72.19.

ICD-9-CM codes 521.8 and V72.1 are **deleted** from the list of codes that do not support medical necessity for the Blood Counts (190.15) NCD.

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190.16 - Partial Thromboplastin Time (PTT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT)(190.16) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31, 277.39, 289.81, 649.30, 649.31, 649.32, 649.33, 649.34, 649.50, 649.51, 649.53, 998.12, 995.20, 995.21, 995.27, and 995.29.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT)(190.16) NCD:

- ICD-9-CM codes 238.7, 277.3 and 995.2.

190.17 - Prothrombin Time (PT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31, 277.39, 289.81, 649.30, 649.31, 649.32, 649.33, 649.34, 649.50, 649.51, 649.53, 995.20, 995.21, 995.27, and 995.29.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD:

- ICD-9-CM codes 238.7, 277.3 and 995.2.

190.18 - Serum Iron Studies

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, and 238.79.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD:

- ICD-9-CM code 238.7.

190.20 - Blood Glucose Testing

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD:

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- ICD-9-CM codes 331.83, 528.00, 528.09, 649.20, 649.21, 649.22, 649.23, 649.24 and 780.32.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD:

- ICD-9-CM code 528.0.

190.22 - Thyroid Testing

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD:

- ICD-9-CM codes 331.83, 780.96 and 780.97.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD

- ICD-9-CM code 793.9.

190.23 - Lipids Testing

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD:

- ICD-9-CM codes 277.30, 277.31 and 277.39.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD:

- ICD-9-CM code 277.3.

190.24 - Digoxin Therapeutic Drug Assay

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD:

- ICD-9-CM codes 995.20, 995.21, 995.27 and 995.29.

The following ICD-9-CM code is being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD:

- ICD-9-CM code 995.2.

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190.25 - Alpha-fetoprotein

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Alpha-fetoprotein (190.25) NCD:

- ICD-9-CM codes V86.0, V86.1, 795.89 and 338.3.

190.26 - Carcinoembryonic Antigen

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Carcinoembryonic Antigen (190.26) NCD:

- ICD-9-CM codes 795.81, 795.89 and 338.3.

190.27 - Human Chorionic Gonadotropin

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD:

- ICD-9-CM codes 795.89 and 338.3.

190.28 - Tumor Antigen by Immunoassay CA 125

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Tumor Antigen by Immunoassay CA 125 (190.28) NCD:

- ICD-9-CM codes 795.82, 795.89 and 338.3.

190.29 - Tumor Antigen by Immunoassay CA 15-3/CA27.29

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Tumor Antigen by Immunoassay CA 15-3/CA27.29 (190.29) NCD:

- ICD-9-CM codes 338.3 and 795.89.

190.30 - Tumor Antigen by Immunoassay CA 19.9

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Tumor Antigen by Immunoassay CA 19.9 (190.30) NCD:

- ICD-9-CM codes 338.3 and 795.89.

190.31 - Prostate Specific Antigen (PSA)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD:

- ICD-9-CM codes 600.00, 600.10, 600.11, 600.21, 788.64 and 788.65.

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190.32 - Gamma Glutamyl Transferase (GGT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (GGT) (190.32) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31 and 277.39.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (GGT) (190.32) NCD:

- ICD-9-CM codes 238.7 and 277.3.

190.33 - Hepatitis Panel/Acute Hepatitis Panel

The following ICD-9-CM code of 780.32 is being **added** to the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

190.34 - Fecal Occult Blood Test (FOBT)

The following ICD-9-CM codes are being **added** to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD:

- ICD-9-CM codes 284.2 and 338.3.

The following ICD-9-CM codes are being **deleted** from the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD:

- ICD-9-CM code 995.2.

List of denied ICD-9-CM codes for all NCDs

The following ICD-9-CM codes are being **added** to the list of denied ICD-9-CM codes for all NCDs:

- ICD-9-CM codes V18.51, V18.59, V82.71 and V82.79.

ICD-9-CM code V18.5 is **deleted** from the list of denied ICD-9-CM codes for all NCDs.

The implementation date for CR 5293 is October 2, 2006.

Additional Information

To see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1050CP.pdf> on the CMS Web site.

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

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Independent Laboratory Billing: Technical Component (TC) of Physician Pathology Services

Provider Types Affected

Independent laboratories that bill Medicare carriers

Impact of CR5210 on Independent Laboratories

Independent laboratories may not bill for the Technical Component (TC) of physician pathology services furnished to a patient of a hospital after December 31, 2006.

Background

In CR 5210, the Centers for Medicare & Medicaid Services' (CMS) proposes to implement the 1999 final physician fee schedule regulations (at 42 CFR § 415.130).

Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital inpatients.

Section 732 of the Medicare Modernization Act (MMA) extended, for 2005 and 2006, the provision of section 542 of the Benefits Improvement Act of 2000 (BIPA) that allowed certain independent laboratories to bill under the physician fee schedule for the technical component of physician pathology services furnished to patients of a covered hospital.

CR 5210 instructs Medicare carriers to **notify all independent laboratories that they may no longer bill** for these services after the MMA provision expires on December 31, 2006.

Implementation

The implementation date for this instruction is December 1, 2006.

Additional Information

To review the related article that extended the provision of Section 542 of the Benefits Improvement Act of 2000 (BIPA) for services furnished in 2005 and 2006 go to <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM3467.pdf> on the CMS Web site.

The official instructions, CR 5210, issued to your Medicare carrier regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1046CP.pdf> on the CMS Web site.

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 Contact Center at 1-877-567-9232.

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

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

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

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Local Coverage Determination Updates: October 2006

LCD	Change	Effective Date Services performed on or after:
Individual Psychiatric Therapeutic Procedures 2002-20LR6	Retired	8/8/2006
Noninvasive Vascular Testing (NIVT) 2001-21LR21	Language changes made under Utilization Guidelines section regarding frequency.	8/1/2006
Erythropoiesis Stimulating Proteins for Patients Not On Dialysis 2002-1LR12	Added Epoetin alfa and darbepoetin alfa as indicated for the treatment of secondary anemia in lieu of ribavirin-interferon dose induced anemia in Hepatitis C. Addition of ICD-9 codes 070.41, 070.44, 070.51, 070.54, 070.70, 070.71, and 995.2. Removed from policy all “column 1” diagnoses (ICD-9 codes 285.9, 284.8, 285.0, and 285.29).	9/1/2006

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Medicare Publication Subscription Form

Subscription: October 2006 through September 2007

Please type or print legibly.

NAME

PRACTICE OR BUSINESS NAME

ADDRESS

CITY

STATE

ZIP

AREA CODE & PHONE NUMBER

Yes, I want to stay current with Medicare Part B developments. My \$100.00 payment for a twelve-month subscription to Medicare Advisories and Special Bulletins is enclosed.

Please make your check or money order payable to:

PALMETTO GBA

Complete this form and send it and your \$100 payment to:

ATTN DALE BATES / DISCLOSURE
MEDICARE PART B SUBSCRIPTIONS
PALMETTO GBA
PO BOX 182934
COLUMBUS OH 43218 – 2934

If you want to receive more than one subscription, please copy this form and submit a separate form for each subscription.
Thank you.

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Medicare Part B Refund and Overpayment Form

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

Provider Information (Must be Completed)

Name: _____
Address: _____

Provider Number: _____
Contact Person: _____

Provider/Office Personnel Signature:

For OIG Reporting Requirements
Do you have a Corporate Integrity Agreement with OIG?

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

Patient's Name: _____
Medicare Number (HIC) (Include Suffix): _____

Claim Number(s) _____
Service Date(s): _____
Procedure Code: _____
Overpaid Amount: _____

Yes No

Medicare Secondary Payer Reason For Overpayment

(Must be completed for MSP overpayments. Please circle the appropriate number.
For multiple overpayments, please identify each reason. Use an attachment, if needed)
Please include a copy of the primary insurance remittance for the service(s) in question

Medicare Secondary Payer (MSP)

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

Secondary Insurance:

Insurance Name: _____
Insurance Address: _____
Insured's Name: _____
Employee's ID Number: _____
Primary Payer's Allowance: _____
Primary Payer's Payment: _____

Please send a check for the entire amount of the claim when the primary insurance payer has not been determined.

Reason For Overpayment/Refund

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

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

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

All refund checks must be addressed to:

Palmetto GBA,
Medicare Part B or
Medicare

Any checks addressed differently cannot be accepted for deposit.

Please mail to the following address:

Palmetto GBA
Medicare Part B Debt Collection Unit
P.O. Box 182934
Columbus, OH 43218-2934

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Medicare Opt Out Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) Bonus Program

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

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

Signature: _____

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

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

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

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

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

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

If you wish to Opt Out of the HPSA bonus and/or PSA bonus program,

please send completed form to:

Attention: Robert Reese, HPSA/PSA Specialist

Medicare Part B

Palmetto GBA

P.O. Box 182934

Columbus, Ohio 43218-2934

Or FAX completed form to:

Robert Reese, HPSA/PSA Specialist

614 - 473 - 6805

Palmetto GBA

Post Office Box 182934 • Columbus, Ohio • 43218-2934

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

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



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

If your redetermination decision is dated prior to 1/1/06, you may still request a carrier hearing officer hearing. Use the form found on our Web site at <http://www.PalmettoGBA.com>.

General Information

Patient's name _____
 Health Insurance Claim (HIC) number _____
 Date of initial determination _____
 CPT code(s) _____
 ICD-9 code(s) _____
 Performing provider number _____
 Billing provider number _____
 Phone number _____
 Date of service _____

This is an appeal for:

- | | | |
|---|--|--|
| <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"/> CRD/ESRD service | <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"/> Office Notes |
| <input type="checkbox"/> Advance Notice Statement | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Claim Copy | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Medical Necessity Statement | <input type="checkbox"/> Treatment Plan |

Reason for request: _____

Requestor (signature required): _____ Date: _____

Address: _____

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

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Reconsideration Request Form - QIC West (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. **To help us serve you better, please include a copy of the redetermination notice with your reconsideration request.**

**Q2 Administrators, LLC
Part B West Operations
PO Box 100213
Columbia, South Carolina 29202-0213**

1. Name of Beneficiary: _____

2. Medicare Number: _____

3. Provider Name and Number: _____

4. Person Appealing: Beneficiary Provider of Service Representative

5. Address of Person Appealing: _____

6. Item or service you wish to appeal: _____

7. Date(s) of service: ___/___/___ TO ___/___/___

8. Does this appeal involve an overpayment: Yes No

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

10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:

- | | | |
|----------------------------------|-------------------------------|----------------|
| Medical Records | A copy of the Claim | Treatment Plan |
| Certificate of Medical Necessity | Office Notes / Progress Notes | |

11. Printed Name of Person Appealing: _____

12. Signature of Person Appealing: _____ Date: _____

Appeal Number: _____ Contractor Number: 00883
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

Palmetto GBA –Ohio/WV Medicare Part B Carrier (Carrier 00883)
Post Office Box 182934 * Columbus, Ohio * 43218-2394
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 East (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. **To help us serve you better, please include a copy of the redetermination notice with your reconsideration request.**

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

1. Name of Beneficiary: _____
 2. Medicare Number: _____
 3. Provider Name and Number: _____
 4. Person Appealing: Beneficiary Provider of Service Representative
 5. Address of Person Appealing: _____

 6. Item or service you wish to appeal: _____
 7. Date(s) of service: ___/___/___ TO ___/___/___
 8. Does this appeal involve an overpayment: Yes No
 9. Why do you disagree? Or, what are your reasons for your appeal? (Attach additional pages, if necessary.)

 10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:

Medical Records	A copy of the Claim	Treatment Plan
Certificate of Medical Necessity	Office Notes / Progress Notes	
 11. Printed Name of Person Appealing: _____
 12. Signature of Person Appealing: _____ Date: _____
- Appeal Number: _____ Contractor Number: 00884
(The appeal number can be found on the redetermination decision letter after "In Any Inquiry Refer To")

Palmetto GBA –Ohio/WV Medicare Part B Carrier (Carrier 00884)
Post Office Box 182934 * Columbus, Ohio * 43218-2394
Beneficiary Service Center: (800) MEDICARE * Provider Service Center: (877) 567-9232
A CMS Contracted Intermediary and Carrier

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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Call Center

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

TTY 1-877-391-9739

Provider Enrollment Support Line

1-866-308-5439

Electronic Data Interchange (EDI) Technical Support

1-866-308-5438

Medicare Secondary Payer

1-866-308-5442

Telephone Reopenings

1-866-308-5441

Medicare Fraud Hotline

1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

<http://www.PalmettoGBA.com>

Important Sources For You

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

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

Attention: Billing Manager

PRSRST STD
U.S. POSTAGE PAID
Columbus, Ohio
Permit No. 2141