NOTE: Should you have landed here as a result of a search engine (or other) link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the files unless you read, agree to, and abide by the provisions of the copyright statement. **Read the copyright statement now and you will be linked back to here.**

Medicare advisory

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2007, Issue 10 *www.cms.hhs.gov* *www.PalmettoGBA.com* *October 2007*

Administrative Information

Correct Coding Initiative Edits: October 1, 2007 2
CMS Quarterly Provider Update 3
Patient Account Numbers: Change for Paper Claims 3
2008 Participation Enrollment Information 4-5
National Provider Identifier (NPI): Update 6
Transition of the Medigap Claim-Based Crossover Process 7
Mandatory Medigap ("Claim-Based") Crossover Process: Transitioning to COBC 8-10
Sunset of the Physician Scarcity Area Bonus Payment 11
Discontinuance of the UPIN Registry 12-13
Medicare Clinical Trial Policy (CTP) 14

Diagnostic

Ultrasound Diagnostic Procedures 15-16

Drugs & Biologicals

ASP Medicare Part B Drug Pricing Files: October 2007 and Revisions 17-20

Electronic Data Interchange (EDI)

Electronic Funds Transfer (EFT) 21
Healthcare Provider Taxonomy Codes (HPTC): Version 7.1 22-25

Education

Palmetto Place 26
Provider List Serv Registration Form 27

Fee Schedule & Reimbursement

Medicare Physician Fee Schedule Database: October 2007 Update 28-32

Specialty

Ambulance

Denying Separately Billed Services: New Remark Code for Ambulance Services 33

Anesthesia

Anesthesia Services: Furnished by the Same Physician Providing Medical and Surgical Service 34-37

Cardiology

PTA: Clarification of Billing Requirements 38-39
Percutaneous Transluminal Angioplasty (PTA) 40-43

Psychology

Can a Clinical Psychologist Order Neuropsychological Tests? 44

Surgery

Lumbar Artificial Disc Replacement (LADR) 45-46
ASC in CY 2008: Revised Payment System 47-57

Etcetera

Medical Director's Desk 58-62
Medicare Opt Out HPSA and/or PSA Bonus Program 63
Redetermination Request for Medicare 64
Reconsideration Request Forms 65-66

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.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Correct Coding Initiative (CCI) Edits: Version 13.3, Effective October 1, 2007

Background

This article is based on Change Request (CR) 5703 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The latest package of CCI edits, Version 13.3, effective October 1, 2007, and the current Mutually Exclusive Code (MEC) edits will be available at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

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 (AMA'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 13.3, includes 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, and
- Mutually Exclusive Code (MEC) Edits.

Additional Information

The CCI and MEC file formats will be maintained in the Medicare Claims Processing Manual (Chapter 23, Section 20.9) which can be found at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

The official instruction, CR 5703, issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1330CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CMS Quarterly Provider Update

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

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

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

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

Patient Account Numbers: Change for Paper Claims

Effective immediately, due to issues with scanning paper claims, special characters (#, +, *, etc.) in Patient Account numbers will no longer be processed. If Patient Account numbers are submitted with special characters, only the alpha and numeric characters will be included on provider remittance notices.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

2008 Participation Enrollment Information

Soon, Palmetto GBA will mail important information to you regarding participation in Medicare and useful resources for your practice. We anticipate that the CD-ROM will be mailed in November 2007 and will contain the following:

- Cover letter
- Fact Sheet
- Resource & contact listing
- CY 2008 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 http://www.PalmettoGBA.com/boh/fees (Ohio), http://ww.PalmettoGBA.com/bwv/fees (West Virginia) or http://www.PalmettoGBA.com/bsc/fees (South Carolina).

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
- Deleted, invalid and non-covered codes
- 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 2008 Participation Enrollment and Physician Fee Schedule will be available in future editions of the *Medicare Advisory* and on our Web site, http://www.PalmettoGBA.com/boh (Ohio), http://www.PalmettoGBA.com/bwv (West Virginia) or http://www.PalmettoGBA.com/bsc (South Carolina).

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

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 http://www.PalmettoGBA.com/boh (Ohio), http://www.PalmettoGBA.com/bwv (West Virginia) or http://www.PalmettoGBA.com/bsc (South Carolina), clicking on E-mail Updates and following the instructions for registering.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

National Provider Identifier (NPI): Update

Provider Action Needed

This article is informational in nature and is based on Change Request (CR) 5678 which updates Chapter 80 of the *Medicare Claims Processing Manual* to delete references to the May 23, 2007 mandatory date for entry of the National Provider Identifier (NPI) on claims. The effective date for providers to use only the NPI on Medicare claims will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR 5595. That article is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf.

Background

The National Provider Identifier (NPI) final rule, published in the Federal Register on January 23, 2004 (http://www.access.gpo.gov/su_docs/fedreg/a040123c.html); Health and Human Services Department Rules), established the standard for a unique identifier for each health care provider for use in health care transactions. Medicare contractors were to be required to enter NPI in certain items and fields of paper claim forms and electronic equivalents on or after May 23, 2007.

However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. For some time after May 23, 2007, Medicare Fee for Service (FFS) will allow continued use of legacy numbers (Unique Physician Identification Numbers (UPINs) and Provider Identification Numbers (PINs)), as well as accepting transactions with only NPIs. The effective date for providers to use only the NPI only on claims and to cease entering UPINs and PINs will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR 5595. That article is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf. This article reflects CR 5678, which simply amends Chapter 80 of the *Medicare Claims Processing Manual* to reflect that the use of the NPI will be mandated for Medicare FFS claims at a future date.

Additional Information

The official instruction, CR 5678, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1328CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Transition of the Medigap Claim-Based Crossover Process

The Centers for Medicare & Medicaid Services (CMS) has made a decision to delay the use of the new Coordination of Benefits Agreement (COBA) Medigap claim-based identifiers on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) until October 1, 2007. This represents a change from previous CMS direction issued in accordance with Transmittal 283, Change Request (CR) 5662, and the accompanying MLN Matters Article.

Because of the CMS delay, physicians and other suppliers shall inform their billing vendors **not** to include any newly assigned 5-byte COBA Medigap claim-based identifiers, as referenced at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf, on incoming Medicare claims before October 1, 2007. If participating providers or suppliers include the newly assigned COBA Medigap claim-based ID on incoming claims before October 1, 2007, Medicare will **not** cross the claims over to the Medigap insurer.

Providers that use PC-Ace or other free billing Medicare software need to ensure this product is updated to reflect the newly assigned 5-byte COBA Medigap claim-based IDs but must ensure that the new identifiers will not be applied on incoming Medicare claims before October 1, 2007.

Effective with October 1, 2007, and as specified in Transmittal 283, CR 5662, physicians and other suppliers that bill using paper forms, i.e., those granted an exception for billing electronically under the Administrative Simplification Compliance Act (ASCA), shall include the newly assigned 5-byte identifier (number will fall in the range 55000 through 59999) within item 9-D of incoming paper CMS-1500 claim forms. These providers should complete items 9A through 9D, in accordance with previous procedures, to ensure they will successfully trigger a Medigap claim-based crossover. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) in field NM109 of the NM1 segment within the 2330B loop. Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier within field 301-C1 of the T04 segment of their incoming NCPDP claims.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Mandatory Medigap ("Claim-Based") Crossover Process: Transitioning to the Coordination of Benefits Contractor (COBC)

Note: This article was revised on September 3, 2007, to reflect changes CMS made to CR 5601, which was re-issued on August 31, 2007. The CR transmittal number, release date, and the Web address for accessing CR 5601 were revised in this article. All other information remains the same.

Impact to You

This article is based on Change Request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap ("claim-based") crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS' Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate change request (CR 5662) that includes the Web site where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will also receive more detailed information regarding this change via their Medicare contractors' provider newsletters/bulletins and Web sites.

What You Need to Know

October 1, 2007 is the effective date for completing the transition of the Medigap crossover process to the COBC. At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format **and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers.** As CMS' COBC assigns the new COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB Web site so that provider billing staffs may access it for purposes of including the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

What You Need to Do

During June through September, 2007, CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Background

Currently, in accordance with §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed "Medigap claims-based crossover." One of the "other" claims filing requirements for Medigap claim-based crossover is that the participating provider must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

Key Points of CR 5601

Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when -the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB Web site so that contractors **may direct providers to that link for purposes of obtaining regular updates.**

Effective with claims filed to Medicare on October 1, 2007:

- All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.

- All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.

- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.

- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.

- Your Medicare contractor's screening process will also -continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.

If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.

"Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer."**

In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.

Also, the Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):

"A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."

REMEMBER: As CMS' COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers.

Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format**.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5601) issued to your Medicare carrier, A/B MAC, or DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1332CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Sunset of the Physician Scarcity Area (PSA) Bonus Payment

Impact to You

This article is based on Change Request (CR) 5711 that reminds physicians that the PSA bonus under Section 413(a) of the Medicare Modernization Act (MMA) will sunset after December 31, 2007.

What You Need to Know

The PSA bonus is payable for dates of service January 1, 2005 through December 31, 2007. The PSA bonus is **not payable for dates of service after December 31, 2007.**

What You Need to Do

Make certain that your billing staffs are aware of these changes as listed in the Background section below and in the revisions to the *Medicare Claims Processing Manual* chapter 4, sections 250.2.1, 250.2.2 and 250.3.2. The revised manual sections are attached to the official instruction in CR 5711. The Web address for accessing CR 5711 is in the *Additional Information* section of this article.

Background

Section 413(a) of the Medicare Modernization Act (MMA) requires Medicare to pay an additional 5 percent bonus to physicians rendering service in a designated PSA. Physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county or the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural census tract. The bonus payment is based on the amount actually paid, not the amount Medicare approved for each service. **The Key Point of CR 5711 is that** the PSA termination date is December 31, 2007 and is not payable for dates of service after that date.

Additional Information

For complete details regarding this issue, see the official instruction (CR 5711) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1321CP.pdf.

For the CMS Web site with information about HPSA/PSA (Physician Bonuses) and zip code downloadable files you may visit http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Discontinuance of the Unique Physician Identification Number (UPIN) Registry

Note: This article was revised on September 17, 2007, to reflect changes made to CR 5584, which CMS re-issued on September 14, 2007. The article was revised to show that the UPIN Registry Web site and lookup functionality will be available through May 23, 2008. Information was added regarding the release of information, including NPIs, via the NPPES. The CR transmittal number, Web address for accessing CR 5584, and the CR release date were also changed. All other information remains the same.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

What You Need to Know

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf.

What You Need to Do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) Web site at https://nppes.cms.hhs.gov/. See the Background and Additional Information Sections of this article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007 implementation by Medicare.

Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated Web site at http://www.cms.hhs.NationalProvIdentStand/. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN "look-up" functionality as of May 23, 2008.

The CMS discontinued assigning UPINs on June 29, 2007, but CMS will maintain its UPIN public "look-up" functionality and Registry Web site (http://www.upinregistry.com/) through May 23, 2008. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Additional Information

For additional information regarding NPI requirements and use, please see MLN Matters articles, MM 4023 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf) titled *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*, and MM 4293 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf) titled *Revised CMS-1500 Claim Form,* which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR 5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Medicare Clinical Trial Policy (CTP)

Impact to You

This article is based on Change Request (CR) 5719, which implements two changes to the 2000 clinical trial policy by: (1) modifying for clarity the language describing coverage of an investigational item/service in the context of a clinical trial, and, (2) adopting coverage with evidence development (CED). The remainder of the 2000 clinical trials policy continues without change.

CR 5719 states that for items and services furnished on and after July 9, 2007, the routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. The investigational item or service itself is excluded, *unless otherwise covered outside of the clinical trial.*

What You Need to Know

In addition, the National Coverage Determination (NCD) is revised to add coverage with evidence development (CED). CED is for items and services in clinical research trials for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a "reasonable and necessary" determination. CED is determined through the NCD process, and conditional upon meeting standards of patient safety and clinical evidence, items and services not otherwise covered would be considered "reasonable and necessary" in the context of a clinical trial. Coverage determined under CED is implemented via subsequent NCDs, CRs, and *MLN Matters* articles specific to the coverage issue.

What You Need to Do

Make certain your billing staffs are aware of these changes. Medicare contractors will adjust claims processed prior to the implementation date of this change if you bring such claims to their attention.

Background

On June 7, 2000, the President of the United States issued an executive memorandum directing the Secretary of Health and Human Services to "explicitly authorize [Medicare] payment for routine patient care costs and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, the Centers for Medicare & Medicaid Services (CMS) engaged in defining the routine costs of clinical trials and identifying the clinical trials for which payment for such routine costs should be made. On September 19, 2000, CMS implemented its initial Clinical Trial Policy through the NCD process. On July 10, 2006, CMS opened a reconsideration of its NCD on clinical trials in the NCD Manual, section 310.1. CR 5719 communicates the findings resulting from that analysis.

Additional Information

To see the official instruction (CR 5719) issued to your Medicare FI, carrier, DME/MAC, RHHI or A/B MAC, visit http://www.cms.hhs.gov/transmittals/downloads/R74NCD.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Ultrasound Diagnostic Procedures

What Providers Need to Know

CR 5608, from which this article is taken, announces that effective on and after May 22, 2007, the Centers for Medicare & Medicaid Services (CMS) will allow payment for the monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the intensive care unit (ICU) and for operative patients with a need for intra-operative fluid optimization.

Make sure that your billing staffs are aware of this change in the ***National Coverage Determinations (NCD) Manual***, Chapter 1 (Coverage Determinations), Section 220.5 (Ultrasound Diagnostic Procedures) to allow coverage for this procedure.

Background

CR 5608, from which this article is taken, announces:

- Effective for claims with dates of service on and after May 22, 2007, CMS has determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and for operative patients with a need for intra-operative fluid optimization is reasonable and necessary; and

- The previous national non-coverage of cardiac output Doppler monitoring is therefore removed.

Specifically, in CR 5608, CMS amends the Medicare *NCD Manual,* Chapter 1 (Coverage Determinations), Section 220.5 (Ultrasound Diagnostic Procedures), by adding: "Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization" to Category I (covered procedures), and deleting "Monitoring of cardiac output (Doppler)" from Category II (non-covered procedures).

Notes:

There is no specific CPT code for this service. CPT code 76999 is for unlisted ultrasound procedures.

When performed in a hospital setting for ventilated patients in the ICU or for operative patients with a need for ultrasound diagnostic procedures, the professional services only are separately payable when billed using CPT code 76999 with CPT modifier 26 to show professional component.

Such services, when globally billed in a hospital setting with CPT code 76999, will be returned as unprocessable to the provider with a reason code such as 58 denoting "Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."

When such services are billed in a hospital setting as technical services with the CPT code 76999 and HCPCS modifier TC, Medicare will deny the services with the 58 reason code and an M77 remark code to show "Missing/Incomplete/Invalid place of service."

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

When performed in an ambulatory surgery center (ASC), ultrasound diagnostic procedures are covered when performed by an entity other than the ASC if globally billed using CPT code 76999, or the technical and professional components may be separately billed using CPT codes 76999-TC (HCPCS modifier) and 76999-26 (CPT modifier), respectively.

Ultrasound diagnostic procedures professional services billed using CPT codes 76999, 76999-TC (HCPCS modifier), and 76999-26 (CPT modifier) are carrier-priced.

Medicare contractors will not search their files to identify and adjust claims processed prior to the implementation of this change, which are for services rendered on or after May 22, 2007. However, they will adjust such claims when you bring the claims to their attention.

Additional Information

You can find more information about the coverage of esophageal Doppler monitoring of cardiac output by going to CR 5608, located at http://www.cms.hhs.gov/Transmittals/downloads/R76NCD.pdf. You will find the amended *Medicare NCD Manual*, Chapter 1 (Coverage Determinations), Section 220.05 (Ultrasound Diagnostic Procedures), as an attachment to that CR.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Average Sales Price (ASP) Medicare Part B Drug Pricing Files: October 2007 and Revisions to Prior Quarterly Pricing Files

Provider Action Needed

This article is based on Change Request (CR) 5710, which informs Medicare providers of the availability of the October 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP payment files (**if CMS determines that revisions are necessary to the latter files**). CR 5710 also advises Medicare providers that ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP Web page as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP NOC files (**if CMS determines that revisions are necessary to the latter files**). Providers should make certain that your billing staffs are aware of these changes.

Background

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

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Web site at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

As announced in late 2006, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A of the Social Security Act. As part of this effort, CMS reviewed how the terms "single source drug," "multiple source drug," and "biological product" are made operational in the context of payment under section 1847A. For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

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

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be made operational through use of existing specific HCPCS codes or "not otherwise classified" HCPCS codes.

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

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

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

Exceptions are summarized as follows:

The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits were not updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

The payment allowance limits for drugs and biologicals 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 (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after September 18, 2007, the October 2007 ASP file will be available for download from the CMS ASP Web site. If CMS determines that revisions are needed to the January 2007, April 2007, July 2007, and October 2006 ASP payment files, those revised files will also be available for retrieval from the CMS ASP Web page. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP Web page is located at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/. These quarterly files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	**Applicable Dates of Service for Claims Processed or Reprocessed on or after October 1, 2007**
October 2006	October 1, 2006 through December 31, 2006
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007
July 2007	July 1, 2007 through September 30, 2007
October 2007	October 1, 2007 through December 31, 2007

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

Additional Information

To see the official instruction (CR 5710) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1334CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) allows your financial institution to deposit your Medicare payments into accounts designated by you. There is no charge by Medicare for this service. These deposits will appear on your bank statements. Medicare does not use EFT to withdraw money from your account.

EFT will:

- Allow quicker receipt of your payments
- Avoid the possibility of your checks being lost or delayed in the mail
- Increase security for your office (paper checks can be stolen)
- Allow savings in Medicare dollars for paper, printing, and postage

If you are interested in receiving your payments electronically, you will need to complete an EFT application form. In addition to the application, you must include a voided check. This will ensure that we have the correct American Banking Association (ABA) number. Your application cannot be processed without the voided check. To obtain the application, go to http://www.PalmettoGBA.com/boh for Ohio and http://www.PalmettoGBA.com/bwv for West Virginia, and then click on forms. The application is under Electronic Funds Transfer (EFT) Registration Form.

The completed application should be sent to:

Provider Enrollment – EFT Analysts
Palmetto GBA OH/WV
P O Box 182933
Columbus OH 43218-2933

Questions regarding EFT should be referred to our Provider Enrollment Support Line at 1-866-308-5439.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Healthcare Provider Taxonomy Codes (HPTC): Version 7.1

Impact to You

CMS has released the summary of changes reflected in the Health Care Provider Taxonomy Code (HPTC) list version 7.1. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on October 1, 2007.

What You Need to Know

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

What You Need to Do

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

Background

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

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

The HPTCs are updated twice per year, in April and October. The summary of changes for Version 7.1 is noted in the table within this article.

Type of Change	Provider Taxonomy Value Code
Additions	• 207QB0002X • 207RB0002X • 207RT0003X • 207VB0002X • 207ZC0006X • 2080T0004X • 2081N0008X • 2084B0002X • 2084N0008X • 102X00000X • 172V00000X • 246ZC0007X • 252Y00000X • 273100000X • 333300000X

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Revisions	• 207K00000X • 207L00000X • 207LC0200X • 207LP2900X • 208C00000X • 207NI0002X • 207ND0900X • 207NP0225X • 207P00000X • 207PS0010X • 207Q00000X • 207QA0000X • 207QG0300X • 207QS0010X • 207R00000X • 207RA0000X • 207RC0001X • 207RE0101X • 207RG0100X • 207RG0300X • 207RH0000X • 207RI0200X • 207RI0011X • 207RX0202X • 207RN0300X • 207RP1001X • 207RR0500X • 207RS0010X • 207SG0202X • 207SG0203X • 207SM0001X • 207SG0205X • 207T00000X • 207U00000X • 207V00000X • 207VC0200X • 207VX0201X • 207VM0101X • 207VE0102X • 207W00000X • 207X00000X

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued on next page

Continued from previous page

Revisions continued	• 207XS0114X • 207XX0004X • 207XS0106X • 207XS0117X • 207XX0801X • 207XX0005X • 207Y00000X • 207YX0901X • 207YP0228X • 207YX0007X • 207ZP0101X • 207ZP0102X • 207ZB0001X • 207ZP0104X • 207ZP0105X • 207ZC0500X • 207ZD0900X • 207ZF0201X • 207H00000X • 207ZM0300X • 207ZP0007X • 207ZN0500X • 207ZP0213X • 208000000X • 2080A0000X • 2080P0006X • 2080T0002X • 2080N0001X • 2080P0008X • 2080P0202X • 2080P0203X • 2080P0204X • 2080P0205X • 2080P0206X • 2080P0207X • 2080P0208X • 2080P0210X • 2080P0214X • 2080P0216X • 2080S0010X • 208100000X

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Revisions continued	• 2081P2900X • 2081P0010X • 2081P0004X • 208200000X • 2082S0099X • 2082S0105X • 2083A0100X • 2083T0002X • 2083X0100X • 2083P0901X • 2083P0011X • 2084P0005X • 2084P2900X • 2085R0202X • 2085N0700X • 2085N0904X • 2085P0229X • 2085R0001X • 2085R0205X • 2085R0204X • 208600000X • 2086S0120X • 2086S0105X • 2086S0102X • 2086S0129X • 208800000X • 208G00000X • 102L00000X • 176B00000X • 175F00000X • 251E00000X

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

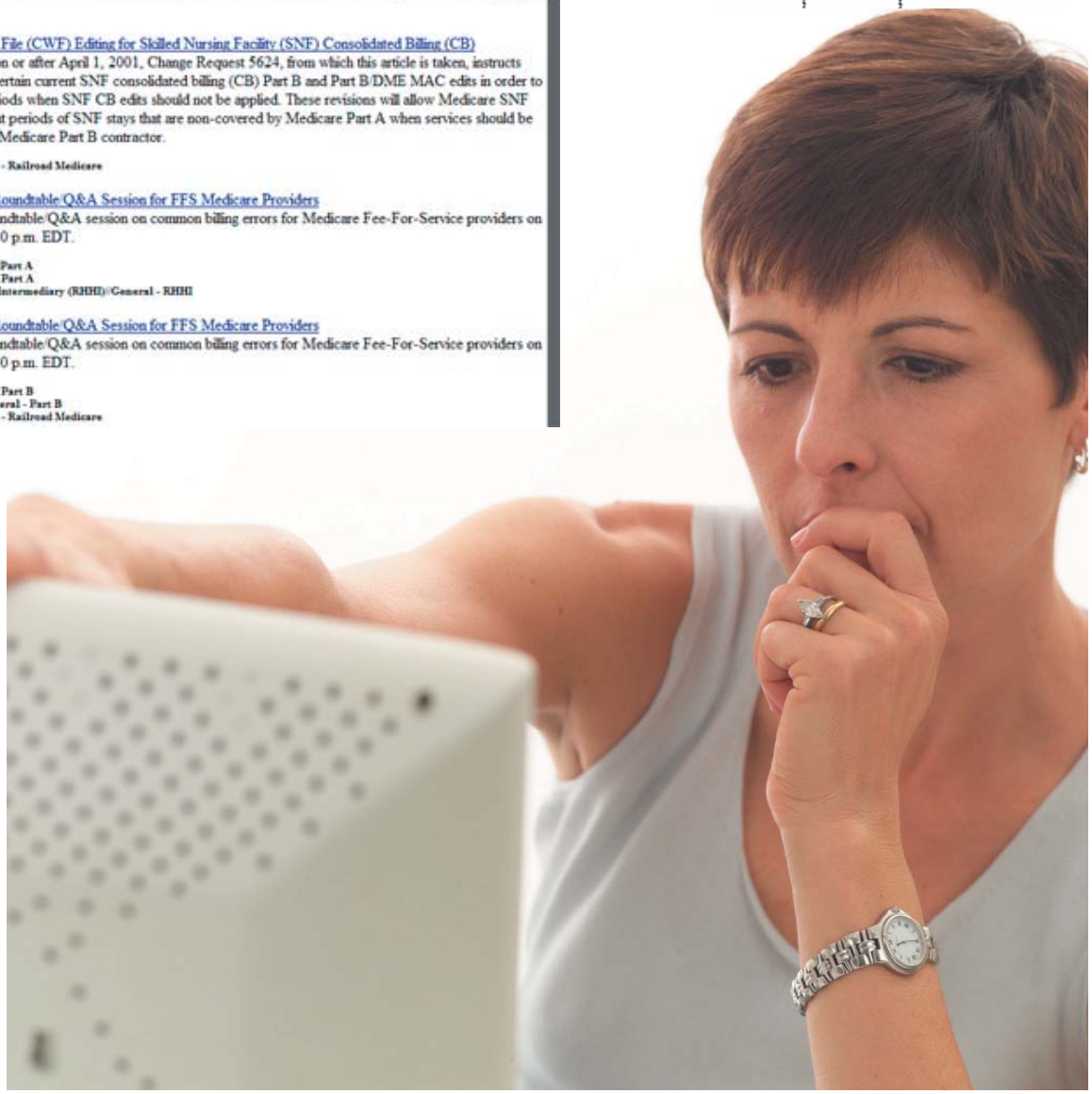
If you have any questions regarding this article, feel free to call the EDI Technical Support help line at 1-866-308-5438.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Palmetto Place

Don’t delay....sign up today.

Wow! These Email Updates that I receive from Palmetto GBA are so helpful. It keeps me up-to-date on the latest Medicare Part B changes and saves me time. It has made my job so much easier...I will have my co-workers register also to make their jobs easier.



CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Medicare Physician Fee Schedule Database: October 2007 Update

What You Need to Know

CR 5714, from which this article was taken, amends the payment files previously issued to your Medicare contractor (based upon the December 1, 2006, Medicare Physician Fee Schedule (MPFS) Final Rule); and includes new codes for the Physician Quality Reporting Initiative.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Medicare contractors, in accordance with the *Medicare Claims Processing Manual*, Chapter 23, Section 30.1, give providers 30 days notice before implementing the revised payment amounts and the changes identified in CR 5714, which (unless otherwise stated in the CR 5714) will be retroactive to January 1, 2007.

You should be aware that carriers will adjust claims that you bring to their attention, but are not required to search their files to either retract payment for claims already paid or to retroactively pay claims.

Changes included in the October Update to the 2007 Medicare Physician Fee Schedule Database are as follows:

The following changes are retroactive to January 1, 2007:

CPT Codes	Action
16035	Global Period = 000 Pre Op = 0.00 Intra Op = 0.00 Post Op = 0.00
20690	Bilateral Indicator = 0
38740	Bilateral Indicator = 1
38745	Bilateral Indicator = 1
54150	Transitional Non-Facility PE RVU = 3.38 Transitional Facility PE RVU = 0.73
64412	Bilateral Indicator = 1
64418	Bilateral Indicator = 1
64613	Bilateral Indicator = 1

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

As stated in Transmittal 1301, dated July 20, 2007, (Change Request 5665 -- Revised Information on PET Scan Coding), effective January 28, 2005, CPT code 78609 became a non-covered service for Medicare purposes.

CPT Code	Procedure Status Indicator*
78609	N
78609 – TC (Technical Component)	N
78609 – 26 (Professional Component)	N

*Effective for dates of service on or after January 28, 2005

New Category II codes for the Physician Quality Reporting Initiative (PQRI)

The following are revisions to the current MPFSDB:

		NON-FACILITY SETTING			FACILITY SETTING		
CPT Code	State	PAR	NON PAR	LMT CHG	#F PAR	#F NON PAR	#F LMT CHG
54150	OH	$190.27	$180.76	$207.87	$96.47	$91.65	$105.40
	WV	$179.70	$170.12	$195.64	$96.72	$91.88	$105.66

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

Effective for dates of service on or after October 1, 2007, the following Category II codes will be added to the MPFS with a status indicator of "M".

CPT Code	Long Descriptor	Short Descriptor
1116F	Auricular or periauricular pain assessed	Auric/peri pain assessed
2035F	Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry	Tymp memb motion exam'd

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

CPT Code	Long Descriptor	Short Descriptor
3215F	Patient has documented immunity to Hepatitis A	Pt immunity to hep a doc'd
3216F	Patient has documented immunity to Hepatitis B	Pt immunity to hep b doc'd
3219F	Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C	Hep c geno tstng doc'd - done
3220F	Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment	Hep c quant rna tstng doc'd
3230F	Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion	Note hring tst w/in 6 mon
3260F	pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report	Pt cat/pn cat/hist grd doc'd
4130F	Topical preparations (including OTC) prescribed for acute otitis external	Topical prep rx, aoe
4131F	Systemic antimicrobial therapy prescribed	Syst antimicrobial thx rx
4132F	Systemic antimicrobial therapy not prescribed	No syst antimicrobial thx rx
4133F	Antihistamines or decongestants prescribed or recommended	Antihist/decong rx/recom
4134F	Antihistamines or decongestants neither prescribed nor recommended	No antihist/decong rx/ recom
4135F	Systemic corticosteroids prescribed	Systemic corticosteroids rx
4136F	Systemic corticosteroids not prescribed	Syst corticosteroids not rx
4150F	Patient receiving antiviral treatment for Hepatitis C	Pt recvng antivir txmnt hepc
4151F	Patient not receiving antiviral treatment for Hepatitis C	Pt not recvng antiv hep c
4152F	Documentation that combination peginterferon and ribavirin therapy considered	Doc'd pegintf/rib thxy consd
4153F	Combination peginterferon and ribavirin therapy prescribed	Combo pegintf/rib rx

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

CPT Code	Long Descriptor	Short Descriptor
4154F	Hepatitis A vaccine series recommended	Hep a vac series recommended
4155F	Hepatitis A vaccine series previously received	Hep a vac series prev recvd
4156F	Hepatitis B vaccine series recommended	Hep b vac series recommended
4157F	Hepatitis B vaccine series previously received	Hep b vac series prev recvd
4158F	Patient education regarding risk of alcohol consumption performed	Pt edu re: alcoh drnkng done
4159F	Counseling regarding contraception received prior to initiation of antiviral treatment	Contrcp talk b/4 antiv txmnt

The payment indicators are identical for all of the above PQRI CPT codes and those indicators are as follows:

- Procedure Status: M
- WRVU: 0.00
- Non-Facility PE RVU: 0.00
- Facility PE RVU: 0.00
- Malpractice RVU: 0.00
- PC/TC: 9
- Site of Service: 9
- Global Surgery: XXX
- Multiple Procedure Indicator: 9
- Bilateral Surgery Indicator: 9
- Assistant at Surgery Indicator: 9
- Co-Surgery Indicator: 9
- Team Surgery Indicator: 9
- Physician Supervision Diagnostic Indicator: 9
- Type of Service: 1
- Diagnostic Family Imaging Indicator: 99

**Effective for services performed on or after October 1, 2007*

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

The short descriptor for HCPCS code G8370 was listed incorrectly in Transmittal 1258, dated May 29, 2007 (Change Request 5614 – July Update to the 2007 Medicare Physician Fee Schedule Database). The short descriptor has been corrected to read:

HCPCS Code	Revised Short Descriptor
G8370	Asthma pt w survey not docum

Additional Information

You can find the official instruction about the October update to the 2007 Medicare Physician Fee Schedule Database by going to CR 5714, located at http://www.cms.hhs.gov/Transmittals/downloads/R1326CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Denying Separately Billed Services: New Remark Code for Ambulance Services

Note: This article was revised on September 10, 2007, to reflect that CR 5659 was revised. The CR transmittal number (see above) and the Web address for accessing CR 5659 were revised. All other information remains the same.

Provider Action Needed

Be aware that contractors will use a new Remittance Advice Remark Code (RARC) message when denying ambulance claims submitted with a code(s) that is not separately billable and already included in the base rate. For claims submitted by ambulance suppliers that Medicare processes on or after October 1, 2007, and which Medicare denies because the code for the service does not appear on the Ambulance Fee Schedule, Medicare will return the RARC of N390 to show "This service cannot be billed separately." See the remainder of this article for further details.

Key Points of CR 5659

Effective October 1, 2007, the new Remittance Advice Remark Code N390 and N185 with Claim Adjustment Reason Code 97, group code CO, will be used when denying any codes on the ambulance claims that does not appear on the Ambulance Fee Schedule.

For such claims processed and denied on or after October 1, 2007, the following Medicare Summary Notice (MSN) message will be sent to Medicare beneficiaries: "16.45 - You cannot be billed separately for this item or service. You do not have to pay this amount."

Background

CR 5659 is the official document that announces these changes in Medicare processes and states that effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when the Centers for Medicare & Medicaid Services (CMS) fully implemented the Ambulance Fee Schedule. Therefore, payment is based solely on the Ambulance Fee Schedule amount as cited in 42 CFR § 414.615 (e) and such payment represents payment in full for all services, supplies, and other costs for an ambulance service furnished to a Medicare beneficiary. CMS was made aware that some providers are submitting claims with ancillary services that are included in the base rate.

CMS decided that a clearer denial message was needed to explain the reason for the denial and that this service is not separately billable and as a result, these claims/services should not be resubmitted. This is true whether the primary transportation service is allowed or denied. Remember that when these services are denied, the services are not separately billable to the beneficiaries.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5659) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1333CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Anesthesia Services: Furnished by the Same Physician Providing the Medical and Surgical Service

Note: This article was revised on August 28, 2007, to reflect changes made to CR 5618 on August 27, 2007. CR 5618 was modified to include the correct Medicare Summary Notice message number for notifying beneficiaries when they are not liable for payment. The CR transmittal number, release date, and the Web address for accessing CR 5618 were also changed. All other information remains the same.

Impact to You

Physicians who both perform, and provide **moderate** sedation for, medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines. However, physicians who perform, and provide **local** or **minimal** sedation for, these procedures will not be paid separately for the sedation services.

What You Need to Know

The *Medicare Claims Processing Manual* (Publication 100-04) Chapter 12 (Physicians/Nonphysician Practitioners) Section 50A (General Payment) is being revised to be consistent with the pricing of the conscious sedation codes under the Medicare physician fee schedule payment system and CPT coding guidelines. In addition, a new section, 50L, explains the payment policy when the same physician performs both the medical/surgical service and the conscious sedation service, is added. Finally, Exhibit 1 that listed the base units by anesthesia code is deleted, because it is out of date and the material is communicated to carriers and Medicare Administrative Contractors (known as A/B MACs) annually via the HCPCS tape.

What You Need to Do

Make sure that your billing staffs are aware of these new payment policies that address the same physician performing both the medical/surgical service and the conscious sedation service.

Background

The continuum of complexity in anesthesia services (from least intense to most intense) ranges from 1) local or topical anesthesia, 2) moderate (conscious) sedation, 3) regional anesthesia, to 4) general anesthesia. Moderate sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

CR 5618, from which this article is taken announces the revision of the anesthesia policy in the *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 50A (General Payment), to be consistent with the pricing of conscious sedation codes under the Medicare physician fee schedule and CPT coding guidelines. It further announces:

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

1) The addition of a new Section (50L), that explains the payment policy if the same physician performs the medical/surgical service and the conscious sedation service; and
2) The deletion of Exhibit 1, that lists the base units by anesthesia code because it is out of date and the material is communicated to the carriers annually via the HCPCS tape.

Currently, section 50A instructs carriers and MACs not to allow separate payment for the anesthesia service performed by the same physician who furnishes the medical or surgical services (for example, there is no separate payment allowed for a surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure; or a psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy).

The revised policy is: If the physician performing the procedure also provides **moderate** sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides **local** or **minimal** sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

Carriers and A/B MACS will not allow payment for CPT codes 99148-99150 if any of these codes are performed on the same day with a medical/surgical service listed in Appendix G of CPT and the service is provided in a non-facility setting. A facility is defined in Chapter 23 Addendum of the *Medicare Claims Processing Manual* as one with a place of service code of 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.

Prior to 2006, Medicare did not recognize separate payment if the same physician both performed the medical or surgical procedure and provided the anesthesia needed for the procedure. The final physician fee schedule published in the Federal Register on November 21, 2005 included newly created CPT codes (99143 to 99150) for moderate (conscious) sedation, which the CPT added in 2006.

Note: These codes have been assigned a status indicator of "C" under the Medicare physician fee schedule designating that these services are carrier priced. CMS has not established relative value units for these services.

Three of these CPT codes (99143, 99144, and 99145) describe the scenario in which the same physician performing the diagnostic or therapeutic procedure provides the moderate sedation, and an independent trained observer's presence is required to assist in the monitoring of the patient's level of consciousness and physiological status. The other three CPT codes (99148, 99149, and 99150) describe the scenario in which the moderate sedation is provided by a physician other than the one performing the diagnostic or therapeutic procedure. CR 5618 presents some specific points that you should be aware of:

CPT coding guidelines for conscious sedation codes instruct practices not to report CPT codes 99143 to 99145 in conjunction with the codes listed in CPT Appendix G. Your carrier or A/B MAC will follow the

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

National Correct Coding Initiative, which added edits in April 2006 that bundled CPT codes 99143 and 99144 into the procedures listed in Appendix G (There are no edits for CPT code 99145; it is an add-on-code and it is not paid if the primary code is not paid.)

In the unusual event that a second physician (other than the one performing the diagnostic or therapeutic services) provides moderate sedation in the **facility** setting for the procedures listed in CPT Appendix G, the second physician can bill CPT code 99148 to 99150, but cannot report these codes when the second physician performs these services (on the same day as a medical/surgical service) in the **non-facility** setting.

If an anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. In this case, the service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.

There is no CPT code for the performance of local anesthesia, and as such, payment for this service is considered to be part of the payment for the underlying medical or surgical service. Therefore, if the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation (such as a local or topical anesthesia), then the conscious sedation code should not be reported and the carrier or A/B MAC will allow no payment.

When denying claims, as appropriate under this policy, carriers and A/B MACs will use:

- Medicare Summary Notice (MSN) message 16.8 when the service is bundled into the other service: "Payment is included in another service received on the same day;" In addition, the MSN (via MSN message 16.45) will note to the beneficiary that "You cannot be billed separately for this item or service. You do not have to pay this amount."

- Claim adjustment reason code (CARC) 97: "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated;"

- Remittance advice remark code (RARC) M80: "We cannot pay for this when performed during the same session as another approved service for this beneficiary." Carriers and A/B MACs will note that the beneficiary is not liable for payment for claims denied as noted in the above MSN message.

- Finally, carriers and A/B MACs will adjust claims, brought to their attention, that were not processed in accordance with the Medicare physician fee schedule data base indicators assigned to the conscious sedation codes.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Additional Information

You can find the official instruction, CR 5618, issued to your carrier or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1324CP.pdf. You will find updated *Medicare Claims Processing Manual* (100-04), Chapter 12 (Physicians/Non-physician Practitioners) as an attachment to that CR.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Percutaneous Transluminal Angioplasty (PTA): Clarification of Billing Requirements

Note: This article was revised on August 30, 2007, to correct the link to MLN Matters article MM3811 on page 2. A link was also added in the Additional Information section to another PTA-related article, MM 5022, which provided clarification of MM 3811. All other information remains unchanged.

Provider Action Needed

This article is based on Change Request (CR) 5667, which adds ICD-9-CM diagnosis code 433.11, occlusion of the carotid artery with infarct, to the list of payable claims for PTA to ensure all eligible Medicare beneficiaries are covered.

Background

On March 17, 2005, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) providing Medicare coverage for Percutaneous Transluminal Angioplasty (PTA) of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). (This was announced in CR 3811, effective March 17, 2005; see related *MLN Matters* article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf.) The NCD provides coverage for patients with symptomatic carotid artery stenosis who meet the coverage criteria specified in the policy. As stated in the NCD,

- Patients who experience non-disabling strokes (modified Rankin scale < 3) are considered to be symptomatic and therefore **are** eligible for coverage; however,

- Patients who experience disabling strokes (modified Rankin scale ≥ 3) **are not** eligible for coverage.

Currently, there are no codes that distinguish between non-disabling and disabling strokes. In order to ensure that claims for all eligible patients can be paid, CR 5667 adds the following International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code of 433.11 (Occlusion and stenosis of carotid artery, with cerebral infarction) to the list of payable claims for carotid artery stenting (CAS).

Patients who experience disabling strokes remain ineligible for coverage.

Note that Medicare contractors will not search their files to reprocess claims already processed. However, they will adjust such claims if you bring the claims to their attention. Also, since the Centers for Medicare & Medicaid Services (CMS) considers this an administrative error, your Medicare contractor will follow the guidelines in the *Medicare Claims Processing Manual* (Chapter 1, Section 70.7.1) for allowing an extension to the timely filing limits. In essence, this allows your contractor to accept claims with 433.11 outside the timely filing limitations, since such claims were not previously payable due to the administrative error. Medicare manuals are available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

CR 5667 also advises providers that they can correctly bill covered bilateral carotid services by coding both 433.30 (Occlusion and stenosis of multiple and bilateral arteries, without mention of cerebral infarction) or 433.31 (Occlusion and stenosis of multiple and bilateral arteries, with cerebral infarction) and 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) or 433.11 in any order on the same claim. Providers would code 433.30 with 433.10 or 433.31 with 433.11 to identify the multiple and bilateral condition and 433.10 or 433.11 to specifically identify the carotid artery.

Claims submitted by physicians to carriers or MACs may also contain CPT code 37215 (Transcatheter placement of intravascular stent(s), cervical carotid artery, Percutaneous; with distal embolic protection), CPT code 0075T (Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel), or CPT code 0076T (Each additional vessel). Claims submitted by institutional providers to FIs or MACs should contain the appropriate procedure codes of 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessels) and 00.63 (Percutaneous insertion of carotid artery stent(s)).

Additional Information

- MM 3489, Percutaneous Transluminal Angioplasty (PTA), can be found at 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.

- MM 5022, Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty (PTA) Concurrent with the Placement of an FDA-approved Carotid Stent, is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5022.pdf.

- The official instruction, CR 5667, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1315CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Percutaneous Transluminal Angioplasty (PTA)

Note: This article was revised on September 13, 2007, to reflect that CMS revised and re-issued CR 5660. The CR release date, transmittal number, and the Web address for accessing CR 5660 were changed. All other information remains the same.

Provider Action Needed

Impact to You

On August 2, 2006, a request to reconsider the national coverage determination (NCD) for PTA and stenting of the carotid arteries initiated a national coverage analysis. Change request (CR) 5660 communicates the findings resulting from that analysis.

What You Need to Know

Effective for dates of service performed on and after April 30, 2007, be aware of:

- Clarifications regarding the use of PTA and stenting of the carotid arteries for patients at high risk for carotid endarterectomy (CEA) and
- **Note the process that facilities must follow for certification and recertification** that is specified in section 20.7 of Publication100-03, the *Medicare National Coverage Determinations Manual*.

What You Need to Do

If you are a provider of PTA and stenting of the carotid arteries services be aware that CMS has reviewed the evidence and determined that **coverage for this NCD is unchanged** and that **facilities should follow the certification/recertification guidelines in CR 5660.** See the *Background and Additional Information* sections of this Medicare Modernization Act (MMA) update.

Background

On April 22, 2005, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 3811 providing Medicare coverage for PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). This national coverage determination (NCD) is contained in section 20.7 of the *Medicare National Coverage Determinations Manual* and the **changes in the NCD are listed below.** To read more about this NCD, click on the article issued with this change request that may be found in *the Additional Information* section of this article.

PTA is covered when used under the following conditions:

- Treatment of Atherosclerotic Obstructive Lesions.
  - In the lower extremities, i.e. the iliac, femoral, and popliteal arteries.
  - In the upper extremities, i.e. the innominate, subclavian, axillary, and brachial arteries, but not head or neck vessels.
  - Of a single coronary artery.
- Concurrent with Carotid Stent Placement.
  - Food and Drug Administration (FDA)-Approved Category B Investigational Device Exemption (IDE) Clinical Trials Effective July 1, 2001.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

- FDA-Approved Post Approval Studies--Effective October 12, 2004.
  Patients at High Risk for Carotid Endarterectomy (CEA)--Effective March 17, 2005.

NOTES: Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.
The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted given the risks of carotid artery stenting (CAS) without distal embolic protection.

- Concurrent with Intracranial Stent Placement
  - FDA-Approved Category B IDE Clinical Trials--Effective November 6, 2006.

CAS for patients who are not at high risk for CEA remains covered only in FDA-approved Category B IDE clinical trials under 42 CFR 405.201.

CMS has determined that PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent is not reasonable and necessary for all other patients.

Facilities Certification
Facilities must be certified for Medicare to cover the CAS procedures and must recertify every two (2) years in order to maintain Medicare coverage of CAS procedures. Recertification will occur when the facility documents that and describes how it continues to meet the CMS standards. The new recertification guidelines are as follows:

At 23 months after initial certification:
- Submission of a letter to CMS stating how the facility continues to meet the minimum facility standards as listed in Section 20.7 of the *Medicare National Coverage Determinations Manual*. (See the *Additional Information* section of this article for the Web link to the NCD within CR 5660)

At 27 months after initial certification:
- Submission of required data elements for all CAS procedures performed on patients during the previous two (2) years of certification.
- Required data elements:
  - Patients' Medicare identification number if a Medicare beneficiary;
  - Patients' date of birth;
  - Date of procedure;
  - Does the patient meet high surgical risk criteria (defined below)?
- Age ≥80;
- Recent (< 30 days) Myocardial Infarction (MI);
- Left Ventricle Ejection Fraction (LVEF) < 30%;
- Contralateral carotid occlusion;
- New York Heart Association (NYHA) Class III or IV congestive heart failure;

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

- Unstable angina: Canadian Cardiovascular Society (CCS) Class III/IV;
- Renal failure: end stage renal disease on dialysis;
- Common Carotid Artery (CCA) lesion(s) below clavicle;
- Severe chronic lung disease;
- Previous neck radiation;
- High cervical Internal Carotid Artery (ICA) lesion(s);
- Restenosis of prior carotid endarterectomy (CEA);
- Tracheostomy;
- Contralateral laryngeal nerve palsy.

Is the patient symptomatic (defined below)?

- Carotid Transient Ischemic Attack (TIA) persisting less than 24 hours;
- Non-disabling stroke: Modified Rankin Scale <3 with symptoms for 24 hours or more;
- Transient monocular blindness:amaurosis fugax;
- Modified Rankin Scale score if the patient experienced a stroke;
- Percent stenosis of stented lesion(s) by angiography;

Was embolic protection used?

Were there any complications during hospitalization (defined below)?

- Stroke: an ischemic neurologic deficit that persisted more than 24 hours
- MI
- Death

Recertification is effective for two (2) additional years during which facilities will be required to submit the requested data every April 1 and October 1.

CMS will consider the approval of national carotid artery stenting registries that provide CMS with a comprehensive overview of the registry and its capabilities, and the manner in which the registry meets CMS data collection and evaluation requirements. Specific standards for CMS approval are listed below. Facilities enrolled in a CMS approved national CAS registry will automatically meet the data collection standards required for initial and continued facility certification. Hospitals' contracts with an approved registry may include authority for the registry to submit required data to CMS for the hospital. A list of approved registries will be made available on the CMS coverage website. In addition, CMS will publish a list of approved facilities in the Federal Register.

National Registries

As noted above, CMS will approve national registries developed by professional societies and other organizations and allow these entities to collect and submit data to CMS on behalf of participating facilities to meet facility certification and recertification requirements. To be eligible to perform these functions and become a CMS approved registry, the national registry, at a minimum, must be able to:

- Enroll facilities in every US state and territory;
- Assure data confidentiality and compliance with HIPAA;

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

- Collect the required CMS data elements as listed above;
- Assure data quality and data completeness;
- Address deficiencies in the facility data collection, quality, and submission;
- Validate the data submitted by facilities, as needed;
- Track long term outcomes such as stroke and death;
- Conduct data analyses and produce facility specific data reports and summaries;
- Submit data to CMS on behalf of the individual facilities; and
- Provide quarterly reports to CMS on facilities that do not meet or no longer meet the CMS facility certification and recertification requirements pertaining to data collection and analysis.

Registries wishing to receive this designation from CMS must submit evidence that they meet or exceed these 10 requirements. Though the registry requirements pertain to CAS, CMS strongly encourages all national registries to establish a similar mechanism to collect comparable data on CEA. Having both CAS and CEA data will help answer questions about carotid revascularization, in general, in the Medicare population.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5660) issued to your Medicare carrier, or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R77NCD.pdf.

The *MLN Matters* article related to CR 3811, which is referenced in the *Background Section* of this article can be reviewed by clicking on the following link http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Can a Clinical Psychologist Order Neuropsychological Tests?

Yes, a **clinical psychologist** may order neuropsychological tests. Other psychologists (educational, counseling, etc.) practicing independently may **not** order diagnostic tests, including neuropsychological tests.

Nonphysician practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit, may be treated the same as physicians treating beneficiaries for the purpose ordering diagnostic tests, including neuropsychological tests.

Reference: Code of Federal Regulations 410.32(a)(3), http://www.gpoaccess.gov/cfr/index.html

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Lumbar Artificial Disc Replacement (LADR)

Note: This article was revised on September 24, 2007, to reflect that CMS issued a second transmittal for CR 5727. The second transmittal, R1340CP, contained revisions to the *Medicare Claims Processing Manual* that reflect the same information contained in the original article.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 5727 that summarizes a national coverage analysis for the reconsideration of the national coverage determination (NCD) for LADR.

What You Need to Know

Effective for dates of service on or after August 14, 2007, LADR is NOT COVERED for Medicare beneficiaries over 60 years of age.

What You Need to Do

Make certain your billing staffs are aware of this change and that you issue the appropriate liability notices to beneficiaries in advance of the procedure consistent with Chapter 30 of the *Medicare Claims Processing Manual* at http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf. **Providers should make certain to issue the Advanced Beneficiary Notice (ABN) and/or (as appropriate) the Hospital Issued Notice of Noncoverage (HINN) to the beneficiary over the age of 60 years who chooses to have LADR.**

Background

On November 28, 2006, the Centers for Medicare and Medicaid Services (CMS) initiated a national coverage analysis for the reconsideration of the NCD on LADR. The original NCD for LADR was focused on a specific lumbar artificial disc implant (CharitеTM) because it was the only one with FDA approval at that time. In the original decision memorandum for LADR, CMS stated that when another lumbar artificial disc received FDA approval CMS would reconsider the policy. Subsequently, another lumbar artificial disc, ProDisc®-L, received FDA approval, which initiated the reconsideration of the NCD on LADR. After reviewing the evidence, CMS is convinced that indications for the procedure of LADR exclude the over age 60 populations; therefore, the revised NCD addresses the procedure of LADR rather than LADR with a specific manufacture's implant.

Key Points

- For services performed on or after August 14, 2007, Medicare contractors will consider LADR a non-covered service for Medicare beneficiaries over 60 years of age as indicated in the Medicare NCD Manual, section 150.10 (see the *Additional Information* section of this article for information on accessing the NCD manual section attached to CR 5727)**. Note: For Medicare beneficiaries 60 years of age and younger, there is no national coverage determination, leaving such determinations to continue to be made by local Medicare contractors.**

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

- Medicare contractors will deny claims submitted with Category III CPT codes 22857 and 0163T for Medicare beneficiaries over 60 years of age, **(i.e. on or after a beneficiary's 61st birthday).**

- Medicare contractors will deny claims submitted with ICD-9-CM procedure code 84.65 for Medicare beneficiaries over 60 years of age.

Where claims are denied:

- Associated Medicare Summary Notices to beneficiaries will contain a message (21.24) indicating "This service is not covered for patients over age 60."

- The associated remittance advice will reflect Claim Adjustment Reason Code 96 "Non-covered charge(s)" and remittance advice remark code N386 ("This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp . If you do not have Web access, you may contact the contractor to request a copy of the NCD."

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5727) issued to your Medicare FI, carrier, or A/B MAC. CR 5727 contains two transmittals, one for the NCD and one for the revised Medicare Claims Processing Manual instructions. These two transmittals may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R75NCD.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R1340CP.pdf.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Ambulatory Surgical Centers (ASC) in CY 2008: Revised Payment System

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS), pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008.

What You Need to Know

CMS has issued a final rule (available at http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage) that describes the revised payment system. Beginning in CY 2008, the revised ASC payment system will provide a transition to the revised rates for currently covered ASC services through three years of transitional payments that are based on a blend of the payment rates from the existing system and the revised payment rates calculated according to the methodology of the revised payment system. CMS also has issued a combined OPPS/ASC proposed rule (available at http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-P(ASC).asp#TopOfPage) that proposes updates to the payment rates and other pertinent ratesetting information for CY 2008.

What You Need to Do

Be sure your billing personnel are aware of the new system and the coding requirements of the new system in order to assure prompt and accurate payment. See the rest of this article for details and watch for additional *MLN Matters* articles as the CY 2008 OPPS/ASC final rule with updated payment rates is published and the system is implemented.

Overview

On August 2, 2007, CMS published a final rule, CMS-1517-F (http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage), establishing the policies for the revised payment system for ASCs. This final rule was followed by a proposed rule, CMS-1392-P (http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-P(ASC).asp#TopOfPage), that proposes the CY 2008 ASC conversion factor and proposed ASC payment rates, in coordination with the proposed hospital Outpatient Prospective Payment System (OPPS) update.

The ASC final rule outlines the policies for the revised ASC payment system to be implemented January 1, 2008. As recommended by the November 2006 Government Accountability Office report on ASC payment, CMS will implement the revised ASC payment system using OPPS relative payment weights as a guide. There are currently about 4,600 ASCs enrolled in Medicare. Total Medicare expenditures for CY 2006 payments to ASCs are estimated at about $2.5 billion. Medicare ASC expenditures for CY 2008 are expected to be approximately $3 billion.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

The final rule greatly expands the types of procedures that are eligible for Medicare payment when performed in the ASC setting and also limits payments for procedures that are performed predominantly in physicians' offices to the amount that would be paid for the non-facility practice expense (PE) under the Medicare Physician Fee Schedule (MPFS). The proposed rule includes no proposals to change these final ASC payment policies.

Background

Since 1982, Medicare has paid for certain surgical procedures, including cataract removal, lens replacement, and colonoscopies, when performed in freestanding or hospital-based ASCs. Currently, Medicare pays for more than 2,500 surgical procedures on the ASC approved list, based on a simple fee schedule comprised of nine unadjusted prospectively determined payment rates. The rates of the nine payment groups, prior to the "limitation on payments" adjustment, range from $333 to $1339. Provider payments include a separate adjustment for geographic wage variations. Medicare makes a separate payment to physicians for professional services. ASC payment rates were last rebased in March 1990 using cost, charge, and utilization data from a 1986 survey of ASC costs.

With the passage of the MMA, Congress required CMS to revise the ASC payment system no later than January 1, 2008. In August of 2006, CMS issued a proposed rule encompassing proposed changes to OPPS policies and payment rates for CY 2007 and the proposed new payment methodology for ASCs. The OPPS and CY 2007 ASC provisions were finalized in November 2006, and the CY 2008 ASC policies related to the revised payment system were finalized in the August 2, 2007 final rule.

Provisions in the Final and Proposed Rules

Expanded List of ASC Procedures:

In the ASC final rule, CMS expands access to procedures in the ASC setting by providing ASC payment for approximately 790 additional surgical procedures in CY 2008. CMS excludes from Medicare ASC payment only those surgical procedures determined to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure in the ASC.

CMS continues to identify surgical procedures as those listed by the American Medical Association (AMA) within the surgical range of Current Procedural Terminology (CPT) codes. CMS also includes within the scope of surgical procedures those services that are described by alphanumeric Healthcare Common Procedure Coding System (HCPCS) codes (Level II HCPCS codes) or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range.

In the OPPS/ASC proposed rule for CY 2008, CMS proposes to make a few revisions to the list of covered surgical procedures by adding several procedures to the list and updating the list of covered ancillary services in coordination with the proposed OPPS update. In addition, based on review of the most recent

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

utilization data, a number of surgical procedures newly added for payment in CY 2008 in the ASC final rule are proposed to be designated as office-based procedures in the proposed rule and, therefore, would be subject to the "office-based" payment methodology that CMS outlined in the final rule.

Revised Payment Rates:
The revised ASC payment rates will be based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. Per the MMA, the revised ASC payment system is budget neutral. That is, the payment rates are intended to ensure that Medicare expenditures under the revised payment methodology for ASCs in CY 2008 will approximate the expenditures that would have occurred in the absence of the revised ASC payment system.

To establish the budget neutrality adjustment for the revised ASC payment system, CMS took into account the expected migration of surgical procedures among ASCs, physicians' offices, and hospital outpatient departments (HOPDs). CMS assumed that approximately 25 percent of the HOPD volume of new ASC surgical procedures will migrate from hospitals to ASCs during the first two years of implementation of the revised ASC payment system and that 15 percent of the volume of new ASC surgical procedures currently provided in physicians' offices will migrate to ASCs during the first four years of the revised ASC payment system. CMS makes no proposal to revise this methodology in the OPPS/ASC proposed rule.

The illustrative budget neutrality adjustment for CY 2008 in the final rule is based on those assumptions and estimated CY 2008 OPPS and MPFS rates and full CY 2005 utilization data. The estimated ASC CY 2008 budget neutrality adjustment factor in the final rule is 67 percent. In the proposed rule, the budget neutrality adjustment factor is somewhat lower, 65 percent, due to proposed changes in OPPS payment rates as a result of APC recalibration, including the proposal to expand the size of the OPPS payment bundles, as well as use of CY 2006 claims and utilization data. Based on the budget neutrality adjustment factor in the proposed rule, the proposed ASC conversion factor for CY 2008 is calculated as 0.65 x $63.693 (proposed CY 2008 OPPS conversion factor) = $41.400.

The standard ASC payment for most ASC covered surgical procedures is calculated as the product of the estimated ASC conversion factor and the ASC relative payment weight (set based on the OPPS relative payment weight) for each separately payable procedure. Per Section 626 of the MMA, contractors will pay ASCs based on the lesser of the actual charge or the standard ASC payment rate. Payment rates for surgical procedures that are commonly performed in physicians' offices and for the technical component of covered ancillary radiology procedures cannot exceed the MPFS non-facility PE amount. Payments to ASCs for covered surgical procedures and certain covered ancillary services are geographically adjusted using the Inpatient Prospective Payment System (IPPS) pre-reclassification wage index values, with 50 percent as the labor-related factor.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Implementation and Updates:
There is a four year transition period for implementation of the rates for procedures on the CY 2007 ASC list of covered procedures. For those procedures, payment will be based on a blend of the revised ASC payment rates and the current ASC rates. Thus, for CY 2008, the payment rates for procedures subject to the transition are comprised of a 25/75 blend, specifically 25 percent of the CY 2008 revised ASC rate plus 75 percent of the CY 2007 ASC rate; in CY 2009, the ratio will change to 50/50; and for CY 2010 it will be 75/25. Beginning in CY 2011, ASC payment rates will be calculated according to the policies of the revised payment system. HCPCS codes newly payable in the ASC setting beginning in CY 2008 will not be subject to this blended transitional payment methodology.

In the annual updates to the ASC payment system, CMS will set ASC relative payment weights equal to the OPPS weights and then scale the ASC weights in order to maintain budget neutrality in the ASC payment system. Without scaling, changes in the OPPS relative payment weights for nonsurgical services could cause an increase or decrease in ASC expenditures due to differences in the mix of services provided by HOPDs and ASCs. For CY 2008, the final payment rates will be published in the CY 2008 OPPS/ASC final rule issued later this year. CMS also will publish an additional *MLN Matters* article around this time.
The statute requires a zero percent ASC update through CY 2009. Beginning in 2010, CMS will update the ASC conversion factor by the Consumer Price Index for All Urban Consumers (CPI-U).

ASC Payment for Device-Intensive Procedures:
A modified payment methodology will be used to establish the ASC payment rates for device-intensive procedures, defined as ASC covered surgical procedures that, under the OPPS, are assigned to APCs for which the device cost is greater than 50 percent of the APC's median cost. Payment for the high cost devices is packaged into the associated procedure payments under the revised ASC system, as it is under the OPPS. CMS pays the same amount for the device-related portion of the procedure cost under the revised ASC payment system as under the OPPS. However, payment for the service portion of the ASC rate will be calculated according to the standard ratesetting methodology, using the ASC budget neutrality adjustment. Therefore, using the budget neutrality adjustment factor in the proposed rule, the service portion of the proposed ASC payment for the device-intensive procedure would be about 65 percent of the corresponding OPPS service payment, just like the payment for other surgical procedures under the revised ASC payment system. The sum of the ASC device and service portions constitutes the complete ASC device implantation procedure payment. ASCs will no longer bill separately for these devices.

The same policy related to full credit and no cost implantable device replacement that applies to the OPPS will apply to ASC payments. That is, when a replacement device is supplied to the ASC at no cost or with full credit by the manufacturer, Medicare ASC payment for the procedure to implant the device will be reduced by the device portion of the ASC payment to account for the lower cost to the facility to furnish the procedure. Medicare provides the same amount of payment reduction based on the estimated device cost included in the ASC procedure payment that would apply under the OPPS for performance of those procedures under the same circumstances.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

In the proposed rule, CMS proposes to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged when an ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction would apply to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. The proposed policy mirrors the proposed policy under the OPPS for CY 2008.

Payment for ASC Covered Ancillary Services:
CMS will pay separately for certain covered ancillary services that are provided integral to covered surgical procedures in ASCs. The ancillary services must be provided immediately before, during, or after a covered surgical procedure to be considered integral and thereby, eligible for separate payment. Medicare also will provide separate payment to the ASC for drugs and devices that are eligible for pass-through payment under the OPPS.

In the proposed rule, CMS proposes to revise the definitions of "radiology and certain other imaging services" and "outpatient prescription drugs." The proposed revised definitions would exclude those ASC covered ancillary radiology services and covered ancillary drugs and biologicals from designation as "designated health services" subject to physician self-referral prohibitions.

As described above, payment for covered ancillary radiology services is made to ASCs at the lesser of the ASC rate or the amount of the nonfacility PE under the MPFS. To ensure that no duplicate payment is made, only ASCs may receive separate payment for the technical component of the covered ancillary radiology services that are separately payable under the OPPS.

Under the revised ASC payment system, Medicare will pay separately for all drugs and biologicals that are separately paid under the OPPS when they are provided integral to covered surgical procedures. Payment will be equal to the OPPS payment rates, without application of the ASC budget neutrality adjustment. In addition, as in the OPPS, the ASC payment rates for these items will not be adjusted for geographic wage differences.

CMS will make separate payment at contractor-priced rates for devices that have pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. CMS also provides separate payment for brachytherapy sources at the OPPS rates, or contractor-priced rates if OPPS rates are unavailable. CMS is proposing prospectively established payment rates for these sources in CY 2008 for both HOPD and ASC settings.

There is no change to payment policy for corneal tissue acquisition. Payment for corneal tissue acquisition will continue to be made at reasonable cost when corneal transplants are performed in ASCs.

No other providers or suppliers may bill for covered ancillary services provided in ASCs integral to covered surgical procedures. This policy will ensure that packaged or separate payment is made to ASCs for all

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

covered ancillary services integral to the performance of covered surgical procedures, thereby providing appropriate payment to ASCs for those services that are essential to the delivery of safe, high quality surgical care.

Physician Payment for Non-Covered ASC Procedures:
ASCs currently receive facility payments under the ASC payment system only for surgical procedures included on a list of ASC covered procedures. They receive no facility payment for any other procedures. Physicians are paid for their PE based on the facility PE relative value units (RVUs) for performing surgical procedures that are on the list. They are paid based on the non-facility PE, or technical component RVUs, for performing services that are not included on the list.

To make the payments to physicians who furnish noncovered procedures in ASCs more consistent with the policy under the OPPS, and in recognition that under the revised ASC payment system only procedures that have been determined to pose a significant safety risk or are expected to require an overnight stay are excluded from the ASC list, CMS proposes to pay physicians at the facility PE payment amount, rather than the non-facility PE amount, for furnishing noncovered procedures in ASCs.

New and Revised Billing Procedures

Reporting Separately Payable Ancillary Services:
As described above, beginning January 1, 2008, Medicare will make separate payment to ASCs for certain ancillary items and services such as drugs and biologicals, brachytherapy sources, radiological procedures, and pass-through devices when they are provided integral to ASC covered surgical procedures. ASCs must report separately payable ancillary services with an accurate number of units in order for correct payment to be made. ASCs should be mindful of dosages of drugs and biologicals and the units included in the HCPCS code descriptors when reporting units. Inaccurate reporting of units for HCPCS codes may result in under- or overpayment.

For example, a typical dosage for the drug reported by HCPCS code J1260 (Injection, dolasetron mesylate, 10mg) is 100 mg. ASCs using 100 mg in the care of a patient will report a 100 mg dose of dolasetron mesylate as 10 units of HCPCS code J1260. Failure to report the correct number of units will result in under- or overpayment. In the case of J1260, if the ASC were to report only one unit for HCPCS code J1260, when it provided one 100 mg dose, it would receive only one-tenth of the Medicare payment for that drug.

Additionally, ASCs will bill separately for devices that have pass-through status under the OPPS when provided integral to covered surgical procedures and, therefore, will be paid separately under the revised ASC payment system. ASCs should use the appropriate Level II HCPCS codes to report the devices. Only two devices currently have pass-through status under the OPPS: C1821 (Interspinous process distraction device (implantable)) and L8690 (Auditory osseointegrated device, includes all internal and external

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

components). For these two devices only, ASCs should report the code for the device and its charge. The Medicare contractor will determine the payment amount for each of the pass-through devices.

ASCs also will need to report the number of units for brachytherapy sources that are provided integral to covered surgical procedures. Medicare will pay the same amount for the sources under the revised ASC payment system as it pays hospitals under the OPPS if prospective OPPS rates are available. The ASC will report and charge Medicare and the beneficiary coinsurance for all brachytherapy sources that are ordered by the physician for a specific beneficiary, acquired by the ASC, and implanted in the beneficiary in the ASC in accordance with high quality clinical care standards.

In the case where most, but not all, prescribed and acquired sources are implanted in the beneficiary, Medicare will cover the relatively few brachytherapy sources that were ordered and acquired but not implanted due to specific clinical consideration. These non-implanted sources may be billable to Medicare only under the following circumstances:

- The sources were specifically acquired by the ASC for the particular beneficiary according to a physician's prescription that was consistent with standard clinical practice and high quality brachytherapy treatment. The sources that were not implanted in that beneficiary were not implanted in any other patient;

- The sources that were not implanted were disposed of in accordance with all appropriate requirements for their handling; and

- The number of sources used in the care of the beneficiary but not implanted would not be expected to constitute more than a small fraction of the sources actually implanted in the beneficiary.

Reporting Charges for Separately Payable Procedures and Services:
Under the revised payment system, ASCs must report charges for all separately payable procedures and services in order to receive correct payment. Medicare contractors will make payment based on the lower of actual charges for separately payable procedures and services, or the ASC payment rate. ASCs should not report separate line item HCPCS codes or charges for procedures, services, drugs, devices, or supplies that are packaged into payment for covered surgical procedures and therefore not paid separately.

Because section 1833(a)(1) of the Social Security Act, as amended by section 626(c) of the MMA, requires ASCs to be paid the lesser of 80 percent of actual charges or the amount that would be paid by Medicare for each separately payable procedure and service, Medicare contractors will compare billed charges to the ASC payment rate at the line-item level. Therefore, it is important that ASCs incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

For example, the single charge reported for a device-intensive procedure should include not only the charges associated with the service such as operating room time and recovery room use, but also the charges associated with the implantable device. Unlike the current ASC payment system, the revised payment system packages device payment into the payment for the associated procedure (i.e., the device is not paid separately). If the ASC bills a procedure code for a device-intensive procedure and fails to include charges for the device in establishing the single line item charge for the covered surgical procedure, the procedure charge may be lower than the Medicare payment rate for that procedure code, which includes payment for the device. The contractor would make payment based on the provider's charges, possibly resulting in underpayment.

Following is a hypothetical example that illustrates the revised payment policy:

Correct Reporting								
Example	CPT Code	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 1: Charges for Packaged Device Rolled Into Charges for Separately Payable Procedure	62361	Implant spine infusion pump	H8	1	$12,000	$10,000	$10,000 x .80 = $8,000	$10,000 x .20 = $2,000
Because the Medicare payment rate is less than the reported charges for CPT code 62361, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $10,000. In this case, the amount set by Medicare for all costs of the procedure is paid.								

* All payment rates are hypothetical.

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Incorrect Reporting								
Example	CPT Code	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 2: Charges for Packaged Device Reported on Different Line from Separately Payable Procedure	62361	Implant spine infusion pump	H8	1	$2,500	$10,000	$2,500 x .80 = $2,000	$2,500 x .20 = $500
	HCPCS Code C1891	Infusion pump, non-programmable, permanent	N1	1	$9,500	N/A	N/A	N/A
Because the reported charges for CPT code 62361 are less than the Medicare payment rate, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $2,500. In this case, the ASC will not receive the amount set by Medicare for all costs of the procedure, due to the ASC's incorrect separate reporting of packaged charges.								

* All payment rates are hypothetical.

Billing Bilateral Procedures:
Bilateral procedures should be reported as a single unit on two separate lines or with "2" in the units field on one line, in order for both procedures to be paid. While use of the -50 modifier is not prohibited specifically according to CMS billing instructions, the modifier will not be recognized for payment purposes and may result in incorrect payment to ASCs. The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting.

The following page provides a hypothetical example that illustrates this payment policy:

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Correct Reporting								
Example	CPT Codes & Modifier	Description	PI	Units	ASC-Reported Charges	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider with Multiple Procedure Reduction	Unadjusted Beneficiary Payment to Provider with Multiple Procedure Reduction
Claim 1: Bilateral Procedure Reported on Two Lines	15823	Revision of Upper Eyelid	A2	1	$1,000	$800	$800 x .80 = $640	$800 x .20 = $160
	15823	Revision of Upper Eyelid	A2	1	$1,000	$800	($800 x .50) x .80 = $320	($800 x .50) x .20 = $80
Because the provider reports the bilateral procedure on two separate lines, and because the multiple procedure reduction applies to 15823, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								
Claim 2: Bilateral Procedure Reported on One Line with Two Units	15823	Revision of Upper Eyelid	A2	2	$2,000	$800 X 2	[$800 + ($800 x 0.50)] x .80 = $960	[$800 + ($800 x 0.50)] x .20 = $240
Because the provider reports the bilateral procedure using “2” in the units field, and because the multiple procedure reduction applies to 15823, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

Incorrect Reporting								
Claim 3: Bilateral Procedure Reported on One Line with Bilateral Modifier	15823 50	Revision of Upper Eyelid	A2	1	$2,000	$800	$800 x .80 = $640	$800 x .20 = $160
Because the provider reports the bilateral procedure using the bilateral modifier, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $800 for only one of the procedures.								

* All payment rates are hypothetical.

Additional Information

For more information regarding this and other ASC issues, CMS encourages you to use the ASC Web page at http://www.cms.hhs.gov/ASCPayment.

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

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

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

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

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

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

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

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

LCD	Change	Effective Date
Cardiac Radionuclide Imaging 2001-41LR11	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 414.2 as supporting medical necessity for CPT codes 78460-78465, 78472, 78473, 78478, 78480, 78481, 78483, 78494, 78496 and HCPCS codes A4641, A9500, A9502, and A9505.	10/01/07
Chemotherapy and Biologicals 2002-29LR31	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 200.30 – 200.78 and 202.70 – 202.78 as supporting medical necessity for HCPCS codes J0207, J1190, J9000, J9020, J9040, J9045, J9050, J9060 – J9065, J9070 – J9097, J9100, J9110, J9150, J9178, J9181 – J9185, J9201, J9206, J9208, J9209, J9213, J9214, J9230, J9250, J9260, J9293, J9310, J9340, J9360, J9370, J9375, J9380, Q2017, A9542, and A9543. Addition of new ICD-9 codes 202.70 – 200.78 as supporting medical necessity for HCPCS codes J9041, J9160 and J9265. Addition of new ICD-9 codes 284.81, 284.89 and 389.13 as supporting medical necessity for HCPCS code J0207. Addition of new ICD-9 codes 284.81 and 284.89 as supporting medical necessity for HCPCS codes J0207 and J9025.	10/01/07
Computed Tomography Angiography (CTA) of the Coronary Arteries 2006-01LR1	ICD-9 2008 Annual Update. Addition of new ICD-9 code 414.2 as supporting medical necessity for CPT code 0146T.	10/01/07
Diagnostic Cardiac Catheterization 2000-4LR9	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 359.21, 359.22, 359.23, 359.24, 359.29, 414.2, and 415.12 as supporting medical necessity for CPT codes 93501, 93510 – 93529 and 93539 –93556. Addition of new ICD-9 code 423.3 as supporting medical necessity for CPT codes 93501, 93541, 93542, 93555 and 93556. Addition of new ICD-9 code V12.53 as supporting medical necessity for CPT codes 93524-93529 and 93539-93556.	10/01/07

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

LCD	Change	Effective Date
Neuromuscular Electrodiagnostic Testing 2001-47LR10.2	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 359.21, 359.22, 359.23, 359.24 and 359.29 as supporting medical necessity for CPT codes 95860 – 95865, 95869-95872, 95900, 95904, 95933 and 95937.	10/01/07
Non-coronary Vascular Stents 2000-45LR8	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 789.51 and 789.59 as supporting medical necessity for CPT codes 37205, 37206, 37207, 37208 and 75960.	10/01/07
Noninvasive Vascular Testing (NIVT) 2001-21LR24	ICD-9 2008 Annual Update. Addition of new ICD-9 code 415.12 as supporting medical necessity for CPT codes 93965 – 93971. Addition of new ICD-9 code 440.4 as supporting medical necessity for CPT codes 93922 – 93931.	10/01/07
Percutaneous Transluminal Angioplasty 2001-10LR9	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 789.51 and 789.59 as supporting medical necessity for CPT codes 35476, 75978 and HCPCS code G0393.	10/01/07
Radiation Oncology Services 2000-03LR20	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 200.3-200.78, 202.70-202.78, and 233.30-233.39 as supporting medical necessity for all CPT codes listed in policy.	10/01/07
Transesophageal Echocardiography 2001-13LR12	ICD-9 2008 Annual Update. Addition of new ICD-9 codes 414.2, 415.12 and 423.3 as supporting medical necessity for CPT codes 93312 – 93318.	10/01/07

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

LCD	Change	Effective Date
Transthoracic Echocardiography 2001-14LR12	ICD-9 2008 Annual Update. Deletion of ICD-9 code 999.3 and addition of new ICD-9 codes 415.12, 423.3, 999.31 and 999.39 as supporting medical necessity for CPT codes 99307, 99308, 93320 and 93321. Deletion of ICD-9 code 933.3 and addition of new ICD-9 codes 414.2, 415.12, 423.3, 999.31 and 999.39 as supporting medical necessity for CPT code 93325. Addition of new ICD-9 code 414.2 as supporting medical necessity for CPT code 93350.	10/01/07
White Cell Colony Stimulating Factors 2002-09LR8	ICD-9 2008 Annual Update. Deletion of ICD-9 code 233.3 and addition of new ICD-9 codes 200.30 – 200.78, 202.70 – 202.78, 233.30, 233.31, 233.32 and 233.39 as supporting medical necessity for HCPCS codes J1440, J1441, J2505 and J2820.	10/01/07

National Coverage Determination Updates

NCD	Change	Effective Date
Cochlear Implantation NCD 50.3	ICD-9 2008 Annual Update. Deletion of ICD-9 code 389.2 and addition of new 2008 ICD-9 code 389.22 as supporting medical necessity for CPT codes 69930 and HCPCS codes L8614 and L8619. Will cover only the following codes as supporting medical necessity for CPT codes 69930 and HCPCS codes L8614 and L8619: ICD-9 codes 389.11, 389.12, 389.18 and 389.22.	10/01/07
Magnetic Resonance Angiography NCD 220.3	ICD-9 2008 Annual Update. Addition of new 2008 Annual ICD-9 code 415.12 as supporting medical necessity for CPT code 71555 and ICD-9 code 440.4 as supporting medical necessity for CPT code 73725.	10/01/07

Continued on next page

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Continued from previous page

NCD	Change	Effective Date
Positron Emission Tomography (PET) Scans NCD 220.6	ICD-9 2008 Annual Update. Addition of new 2008 Annual ICD-9 code 414.2 as supporting medical necessity for CPT codes 78459, 78491, 78492 and HCPCS code A9526. Addition of new 2008 Annual ICD-9 codes 200.30 – 200.78 and 202.70 - 202.78 as supporting medical necessity for CPT codes 78608, 78609, 78811, 78812, 78813, 78814, 78815 and 78816.	10/01/07

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Medicare Opt Out HPSA and/or PSA Bonus Program

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

Provider Name: _____

Practice or Business Name: _____

Address: _____

City, State, ZIP: _____

Phone Number (including area code): _____

Identify All Applicable Medicare Provider Identification Numbers (PINs):

_____

Signature: _____

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

* You may backdate this option, if you wish. If you do not indicate an effective date, the date we receive and approve this form will become your effective date.

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

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

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

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

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

General Information

*Patient's name: _____
*Health Insurance Claim (HIC) number: _____
Claim Number (ICN): _____
Date of initial determination: _____
*Date of Service: _____
*CPT code(s): _____
ICD-9 code(s): _____
Billed Charge: _____

*** Indicates required fields.**

Provider Name: _____
Billing provider number: _____
Provider Phone Number: _____
Who are you:

- ❑ Provider
- ❑ Provider's Representative
- ❑ Patient with Medicare
- ❑ Patient's Representative
- ❑ Other

This is an appeal for:

- ❑ Ambulance service
- ❑ Chiropractic service
- ❑ Surgery
- ❑ Duplicate service
- ❑ Limitation of Liability (LOL) service
- ❑ Podiatry service
- ❑ Psychiatric service
- ❑ Radiology service
- ❑ Other

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

- ❑ Remittance Notice (please attach)
- ❑ Advance Notice Statement
- ❑ Claim Copy
- ❑ Medical Necessity Statement
- ❑ Office Notes
- ❑ Operative/Pathology Report
- ❑ Radiology Report
- ❑ Treatment Plan
- ❑ Ambulance Run Report

Reason for request: _____
_____
_____
_____
_____
_____

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

Name: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Phone Number: _____

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Reconsideration Request Form - QIC North (Ohio)

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

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

1. Name of Beneficiary: _____

2 a. Medicare Number: _____

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

3. Provider Name & Number: _____

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

5. Address of Person Appealing: _____

6. Item or service you wish to appeal: _____

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

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

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

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

11. Printed Name of Person Appealing: _____

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

13. Phone Number of Person Appealing: _____

Contractor Number: 00883

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Reconsideration Request Form - QIC South (West Virginia)

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

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

1. Name of Beneficiary: _____

2 a. Medicare Number: _____

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

3. Provider Name & Number: _____

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

5. Address of Person Appealing: _____

6. Item or service you wish to appeal: _____

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

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

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

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

11. Printed Name of Person Appealing: _____

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

13. Phone Number of Person Appealing: _____

Contractor Number: 00884

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

CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

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

TTY 1-877-391-9739

Provider Enrollment Support Line
1-866-308-5439

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

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

http://www.PalmettoGBA.com

Important Sources For You

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

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

Attention: Billing Manager

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