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Medicare *advisory*

The latest Medicare news for Ohio and West Virginia providers.

Vol. 2007, Issue 9 *www.cms.hhs.gov* *www.PalmettoGBA.com* *September 2007*

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You Are Responsible. . .

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

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

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2008 Annual HCPCS Codes: Skilled Nursing Facility Consolidated Billing & Common Working File

Impact to You

This article is based on Change Request (CR) 5696, which provides the 2008 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

What You Need to Know

CR 5696 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manua*l, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

What You Need to Do

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

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/. Institutional providers note that this site will include new Excel® and PDF format files.

Note: It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at http://www.cms.hhs.gov/SNFConsolidatedBilling/ in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Additional Information

The official instruction, CR 5696, issued to your Medicare contractor regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.pdf.

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

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Protected Health Information: Clarification About The Medical Privacy

Provider Action Needed

The purpose of this Special Edition (SE) article, SE 0726, is to be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- The Privacy Rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- That providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance

HHS' educational materials include a letter to healthcare providers with the following examples to clarify the Privacy Rule.

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the "Treatment/Payment/Health Care Operations" subcategory, or search the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at http://www.hhs.gov/hipaafaq/ on the HHS Web site.

- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf on the HHS Web site.

- Review the "Summary of the HIPAA Privacy Rule" at http://www.hhs.gov/ocr/privacysummary.pdf on the HHS Web site.

HIPAA does not require providers to eliminate all incidental disclosures:

The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.

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OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR Web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the fact sheet on "Incidental Disclosures". The fact sheet is at http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf on the HHS Web site.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.

- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.

- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.

- Review the HHS/OCR Web site FAQs http://www.hhs.gov/hipaafaq/notice/488.html in the sub-category "Disclosures to Family and Friends."

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.

- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.

- See the FAQs in the "Facility Directories" at http://www.hhs.gov/hipaafaq/administrative/ on the HHS Web site.

HIPAA does not prevent child abuse reporting:

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that can be reviewed at http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf on the HHS Web site.

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HIPAA is not anti-electronic:
Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at http://www.hhs.gov/hipaafaq/providers/smaller/482.html on the HHS Web site.

Additional Information

The HHS complete listing of all HIPAA medical privacy resources is available at http://www.hhs.gov/ocr/hipaa/ on the HHS Web site.

For a full list of educational materials, visit http://www.hhs.gov/ocr/hipaa/assist.html on the HHS Web site.

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CERT Records Request Letters: Hints

CMS established the Comprehensive Error Rate Testing (CERT) program to measure the accuracy of Medicare payments. The accuracy of these payments is established through a review of selected claims submitted by health care providers and supporting documentation obtained from the corresponding medical records. **Participation in the CERT review is not optional;** it is imperative that you respond to requests for medical record documentation from the CERT contractor**.** No response = no records = overpayment, and Palmetto GBA OH/WV will request a refund from your practice. Although you have the same appeal rights with Palmetto GBA as in any other situation, this could be an unnecessary, time-consuming process.

To obtain the appropriate documentation for the CERT review, refer to ***both*** the **Bar Coded Sheet** (lists needed records), and the **Medical Records/Documentation Pull List** (it shows the specific codes and rendering provider's number).

If you receive a CERT records request letter, please note:

- You, as the billing provider, are responsible for taking the necessary steps to obtain records, even from third parties, hospitals, nursing homes, etc.
- The CERT Documentation Contractor (CDC) will not pay for in-house or outsourced copying of any requested records. Please do not send them bills or invoices.
- The CERT record request letters do not specify the place of service. JUST procedure codes, modifiers and ICD-9 diagnoses codes are listed. No narrative descriptions are given.
- Only the rendering/performing providers' Medicare Part B numbers will be shown. No actual names and designations are currently given.
- Be careful to obtain the correct records for the specific patient/date or dates of service/code(s) and provider. This is especially true **IF multiple providers from your practice performed services** for the patient during the same time frames outlined in the letter. Pay particular attention to this if inpatient care was involved.
- The ***Claim Date*** and/or ***Universe Date*** are ***NOT*** the dates of service. They describe an "entry" date. It just represents the day when the processing of your submitted claim first began at Palmetto GBA OH/WV. Please see ***Service From/To Dates*** for the actual date(s) of service.
- It is not a violation of HIPAA to send records. NO SIGNED RELEASE IS NEEDED*. Please notify your staff and medical records department of this.

EXCEPTION**: Psychotherapy where ***counseling session note contains *confidential exchanges* between the therapist and patient. However, psychiatric records, which are social/medical/administrative in nature, do not require special authorization, e.g., medication checks.

If you have questions concerning a request letter you have received, please contact the CERT Documentation Office at (301) 957-2380.

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New CMS-1500 & UB-04 Forms: Important Guidance

What You Need to Know

This *MLN Matters* article, SE 0729, provides you valuable information about the new CMS 1500 and UB-04 forms.

Background

CMS Form 1500 Version 08-05

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised Form CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the National Provider Identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with the CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one healthcare vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive, and process, paper claims (using the new [08-05] version of the CMS-1500 form) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised form CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500 form, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at http://www.nucc.org/, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct. Some important details in completing the new CMS-1500 form are as follow:

If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.

The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.

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If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You can learn more about the new version of the CMS-1500 by reading MLN Matters article MM 5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006. You can find that article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf.

UB-04 Information

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the National Provider Identifier (NPI) taxonomy, and additional codes; and is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007 (during which time either the UB-92 or the UB-04 may have been used). On and after May 23, 2007: 1) The UB-92 has become no longer acceptable (even as an adjustment claim); and 2) All institutional paper claims must be submitted on the UB-04.

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.

When filing, you should retain the copy designated “Institution Copy” and submit the remaining copies to your Medicare contractor, managed care plan, or other insurer.

Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.

If you omit any required data, your contractor will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.

Data elements in the CMS uniform electronic billing specifications are consistent with the UB-04 data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because

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of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.

For the UB-04, the billing provider's NPI is entered in Form Locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider's NPI is entered in FL77. Up to 2 other provider NPIs can be entered in FL78 and FL79.

You can find more information about the UB-04 (Form CMS-1450) by reading MLN Matters article MM5072 (Uniform Billing (UB-04) Implementation – UB-92 Replacement), released November 3, 2006. You can find that article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf. The CR, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you can contact the NUBC at http://www.nubc.org/.

Additional Information

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

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Timeliness Standards for Processing 'Other-Than-Clean' Claims

Impact to You

This article is based on Change Request (CR) 5513 which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) published instructions in a separate transmittal to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness standards for processing other-than-clean claims, and CR 5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.

What You Need to Do

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

Background

The Social Security Act (Section 1869(a)(2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm, mandates that Medicare process all "other-than-clean" claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section 1869; http://www.ssa.gov/OP_Home/ssact/title18/1869.htm, further defines the term "clean claim" as meaning "a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title." Claims that do not meet the definition of "clean" claims are "other-than-clean" claims, and they require investigation or development external to the contractor's Medicare operation on a prepayment basis.

A Medicare contractor should process all "other-than-clean" claims and notify the provider and beneficiary of their determination within 45 calendar days of receipt. (See *Medicare Claims Processing Manual,* Publication 100-4, Chapter 1, Section 80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims; http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

However, when the Medicare contractor develops the 'other-than-clean' claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

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EXAMPLE:
A Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/ supplier/ and/or beneficiary until June 5th. In this example, 5 of the 45 allotted calendar days will have already passed before the Medicare contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/ supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and or beneficiary does not respond.
This timeliness standard does not apply:

- Where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC);
- Where there is a problem with the beneficiary's record in Medicare's files **are not subject to this instruction**;
- Where the claim is rejected by the translator software;
- Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly; or
- To claims submitted by a hospice and these claims are to be processed per instructions in the *Medicare Claims Processing Manual* (Chapter 1, Section 50.2.3; http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf)

Additional Information

The official instruction, CR 5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf.

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

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National Provider Identifier (NPI) Crosswalk: Lifting Bypass Logic

Since October 2, 2006, providers have been encouraged to submit both the NPI and Medicare legacy identifier (PIN) on their claims. During this timeframe providers were **not** penalized for invalid NPI/legacy ID combinations.

Effective October 8, 2007, Palmetto GBA will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned to the provider.

When the claim is returned, a provider should first verify that the correct NPI was submitted. If correct, you will need to verify that your legacy identifier (PIN or NSC) number corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES). NPPES data may be checked on line at https://nppes.cms.hhs.gov.

If your NPPES information is correct and you have included and matched ALL Medicare legacy identifiers with a corresponding NPI in NPPES, but you are experiencing provider identifier problems with your claims that contain an NPI, you may need to submit a Medicare enrollment application (i.e., the CMS-855). Please contact our office at 1-866-308-5439 if you need more information.

- More information and education on the NPI may be found at the CMS NPI page, http://www.cms.hhs.gov/NationalProvIdentStand.
- Also, providers can apply for an NPI online at https://nppes.cms.hhs.gov.
- For common billing errors please refer to CMS' article about Common Billing Error, which can be located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf.

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National Provider Identifier (NPI): Medicare's Implementation

This article was revised on August 7, 2007, to delete a reference to the NPI viewlet, which is no longer available on the CMS Web site. Previously, the article was revised on May 18, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM 5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf.

Provider Types Affected

Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain NPIs for those providers should take note of this article.

Part 1: Information That Applies to All Providers

Background

All healthcare providers are eligible to receive NPIs. All HIPAA covered healthcare providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use **only** the NPI to identify covered healthcare providers in standard transactions by **May 23, 2007**. Small health plans must use **only** the NPI by **May 23, 2008**.

Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) Web site, https://nppes.cms.hhs.gov. The NPPES is the only source for NPI assignment.

The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

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- An easy Web-based application process is available at https://nppes.cms.hhs.gov.

- A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at https://nppes.cms.hhs.gov. A copy of the paper application may also be obtained by calling the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies
Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date. also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Sharing Your NPI **Sharing Your NPI**
Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are: Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies); Any provider with which they do business (e.g., pharmacies);

- Health plans with which they conduct business; and Health plans with which they conduct business; and

- Organizations where they have staff privileges. Organizations where they have staff privileges.

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We understand that providers have many questions related to EFI or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES Web site (https://nppes.cms.hhs.gov) and download a certification form.
- The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months. The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

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Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of healthcare providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization healthcare providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities ***"subparts"*** to avoid confusion with the term healthcare "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each healthcare provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI Final Rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, healthcare providers who need billing numbers for federal health programs are actually components of covered healthcare providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.

- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.

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- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.

- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Part 2: Information That Applies to Medicare Fee-For-Service (FFS) Providers Only

All Medicare providers are reminded that they will be required to use the NPI *in Medicare claims transactions.*

NPI Transition Plans for Medicare FFS Providers

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

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing **Medicare** numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 - October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim.** Note that CMS claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007:	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward:	CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

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Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information

Coming Soon: CMS is developing a MLN Web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all MLN Matters articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this Web page in the coming weeks.

- You may wish to visit http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp#TopOfPage regularly for the latest information about the NPI.

- You may go to http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

- The Federal Register notice containing the NPI Final Rule is available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf.

- There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

- You may also find some industry implementation recommendations and white papers on the NPI at http://www.wedi.org, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

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Provider Notification of Medicare Claims: Disputed/ Rejected by Supplemental Payers/Insurers

Provider Action Needed

Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a Dispute Reason Code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

Background

In *MLN Matters* article, MM 3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors. (MM 3709 may be referenced at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf.

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each:

Dispute Reason Codes:

000100 - Duplicate Claim

000110 - Duplicate Claim (within the same ISA – IEA loop)

000120 - Duplicate claim (within the same ST-SE loop)

000200 – Claim for Provider ID/State should have been excluded

000300 - Beneficiary not on eligibility file

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000400 - *Reserved for future use*

000500 - Incorrect claim count

000600 - Claim does not meet selection criteria

000700 - HIPAA Error

009999 – Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all Dispute Reason Codes **except** for 000100, 000110, 000120, and 000400.

Additional Information

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2007 Medicare Contractor Provider Satisfaction Survey (MCPSS): Positive Results for Medicare's Fee-for-Service Contractors

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

Background

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at http://www.cms.hhs.gov/MCPSS.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Additional Information

Please contact our office at 1-877-567-9232 with any questions you may have.

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Laboratory and Radiology: Technical Component For Hospital Patients, Adjustment to Common Working File Duplicate Claim Edit

Impact to You

Previously the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5347 that established duplicate claims edits, which included consideration **of the admission and discharge dates of a hospital stay in identifying duplicate claims for radiology and pathology services.**

What You Need to Know

Effective with implementation of CR 5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid that provide** radiology and pathology services to Medicare beneficiaries on **the day of admission and the day of discharge during an inpatient hospital stay**.

What You Need to Do

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

Background

This CR is being implemented to avoid denying claims that were legitimately provided to beneficiaries on the admission and discharge dates. The general rule is that the technical component (TC) of radiology services provided during an inpatient stay may be billed only by the admitting hospital. Radiology suppliers that render services to beneficiaries in an inpatient stay may not bill the Medicare carrier for the technical portion of the service.

Also, the TC of physician pathology services provided to a hospital inpatient may be billed only by the admitting hospital. Independent laboratories have been instructed that they may not bill for these services after December 31, 2007, per CR 5468 (Transmittal 1148, issued Jan 5, 2007). The **exception is that imaging and pathology services performed on the admission date and discharge date** by entities other than the admitting hospital **are separately payable.**

Also, note that carriers and A/B MACs will not reprocess claims already processed, but they will adjust previously processed claims if affected providers bring such claims to the attention of their carrier or A/B MAC.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5675) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1295CP.pdf. CR 5347 implemented a process to prevent payments of the TC of radiology services furnished to an inpatient of a hospital by any entity other than the admitting hospital. This CR may be reviewed by clicking on http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf.

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

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Competitive Acquisition Program (CAP) for Part B Drugs & Biologicals: Claims and CWF 69XD Error Code

Impact to You

If you submit the same prescription order number more than once on a single CAP claim, your carrier or A/B MAC will return the entire claim as unprocessable.

What You Need to Know

CR 5658, from which this article is taken, instructs carriers and A/B MACs to return as unprocessable CAP claims received with duplicate prescription order numbers.

What You Need to Do

Make sure that your billing staffs are aware that they should not submit the same prescription order number more than once on a CAP claim, nor should they use the JW HCPCS modifier on CAP claims, per CR 5658.

Background

Carriers and A/B MACs receive an error code when the same prescription order number is submitted more than once on a CAP claim. This inclusion of duplicate prescription order numbers on a single claim can happen, for example, when:

- The provider is coding wastage of the drug using the JW HCPCS modifier, and has repeated the prescription order number on the wastage line;
- The units provided for the drug exceed 999 and the balance of the units are coded on an additional line with a repeat of the prescription order number; or
- The provider has submitted more than one line on the same claim with the same or different dates of service using the same prescription order number (even when the units do not exceed 999).

In response to this error code, carriers and A/B MACs will return the claims as unprocessable, using the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) messages:

- CARC 16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. This change to be effective April 1, 2007. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
- Message MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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- New RARC N389: Duplicate prescription number submitted.

- RARC M16: Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

In order to resolve the issue of units that exceed 999, the Centers for Medicare & Medicaid Services (CMS) will be working with the approved CAP vendor to issue additional prescription order numbers when the units of the drug exceed 999.

Finally, CR 5658 rescinds (from CR 4309, issued on February 17, 2006) the instructions that addressed applying the unused drug HCPCS modifier (JW) to indicate billing for the unused portion of a single-use drug product under the CAP. Claims for drugs provided under CAP submitted with the JW HCPCS modifier will be treated as unprocessable. This CR does not affect the use of the JW HCPCS modifier for non CAP claims.

Additional Information

You can find the official instruction, CR 5658, issued to your carrier or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1313CP.pdf.

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

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Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients: Required on or After October 1, 2007

Provider Types Affected

This issue impacts all physicians, practitioners, and other providers who prescribe Medicaid outpatient drugs, including over-the-counter drugs, in States that reimburse for prescriptions for such items. Pharmacists and pharmacy staff especially should be aware of this requirement as it may affect reimbursement for prescriptions. The requirement is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

Background

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007. Section 7002 (b) of that Act addresses the use of tamper-resistant prescription pads and offers guidance to State Medicaid agencies.

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to State Medicaid Directors with guidance on implementing the new requirement.

Key Points of the CMS Letter to Your State Medicaid Director

- As of October 1, 2007, in order for outpatient drugs to be reimbursable by Medicaid, all written, non-electronic prescriptions must be executed on tamper-resistant pads.

- CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each State will define which features it will require to meet those characteristics in order to be considered tamper-resistant. **To be considered tamper resistant on October 1, 2007, a prescription pad must have at least one of the following three characteristics:**

    - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
    - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
    - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

- **No later than October 1, 2008, to be considered tamper resistant, States will require that the prescription pad have all three characteristics.**

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- Several States have laws and regulations concerning mandatory, tamper-resistant prescription pad programs, which were in effect prior to the passage of section 7002(b). CMS deems that the tamper-resistant prescription pad characteristics required by these States' laws and regulations meet or exceed the baseline standard, as set forth above.

- Your State is free to exceed the above baseline standard.

- Each State must decide whether they will accept prescriptions written in another state with different tamper proof standards.

- **CMS believes that both e-prescribing and use of tamper-resistant prescription pads will reduce the number of unauthorized, improperly altered, and counterfeit prescriptions.**

Situations in Which the New Requirement Does Not Apply

The requirement does not apply:

- When the prescription is electronic, faxed, or verbal; (CMS encourages the use of e-prescribing as an effective means of communicating prescriptions to pharmacists.)

- When a managed care entity pays for the prescription;

- To refills of written prescriptions presented to a pharmacy before October 1, 2007; or

- In most situations when drugs are provided in nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, and certain other institutional and clinical facilities.

Note: The letter issued by CMS to State Medicaid Directors states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant prescription within 72 hours after the date on which the prescription is filled. PLEASE NOTE also that Drug Enforcement Administration (DEA) regulations regarding controlled substances may require a written prescription.

Additional Information

To review the letter from the Center for Medicaid and State Operations go to http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf.

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Electronic Funds Transfer: Standardizations & Revisions to the Medicare Claims Processing Manual (Chapter 24)

Impact to You

This article is based on Change Request (CR) 5586 which revises the *Medicare Claims Processing Manual,* Chapter 24 (General **Electronic Data Interchange (EDI**) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will ensure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

What You Need to Do

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

Background

CR 5586 provides the following revisions to the *Medicare Claims Processing Manual* (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers to be Reviewed

Each carrier, DME MAC and B MAC (not FIs or RHHIs at this time) conducts an ASCA review annually of 20% of those providers still submitting CMS 1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a “small” provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider’s “small” status will change within two years of the start of the prior review; or
- Fewer than 30 paper claims were submitted by the provider to Medicare during the prior quarter.

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Electronic Funds Transfer (EFT)

Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of Form CMS-588 (Electronic Funds Transfer Authorization Agreement) to their Carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

Note: Medicare contractors will not approve any requests to change payment method from EFT to check.

Additional Information

The official instruction, CR 5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1284CP.pdf.

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

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Claim Status Category Code and Claim Status Code Update

Impact to You

This article is based on Change Request (CR) 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs)..

What You Need to Know

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the http://www.wpc-edi.com/codes. Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277 discusses these codes in more detail. You may review section 20.7 at: http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf.

What You Need to Do

See the *Background* section of this article for further details.

Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on).The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/content/view/180/223/. This page has previously been referenced by the following URL address: http://www.wpc-edi.com/codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, **changes approved in June 2007 will be effective January 1, 2008.**

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf.

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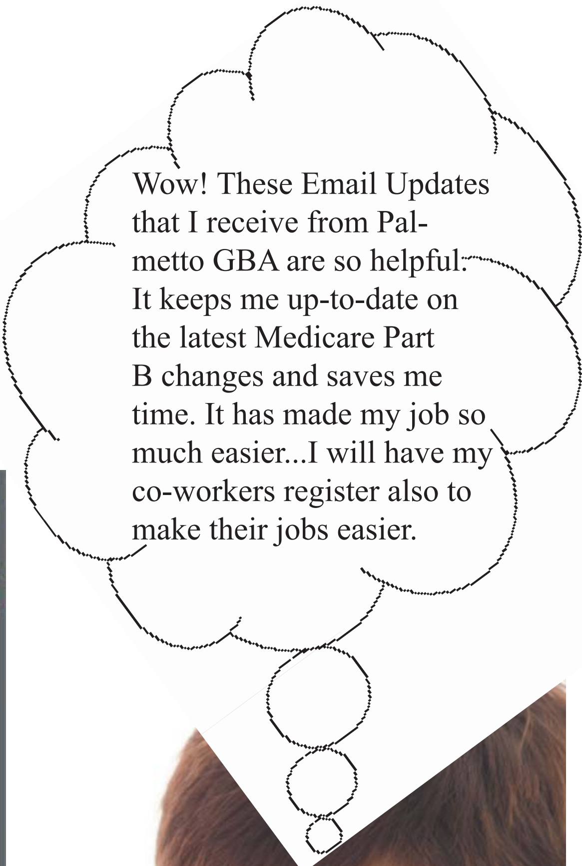

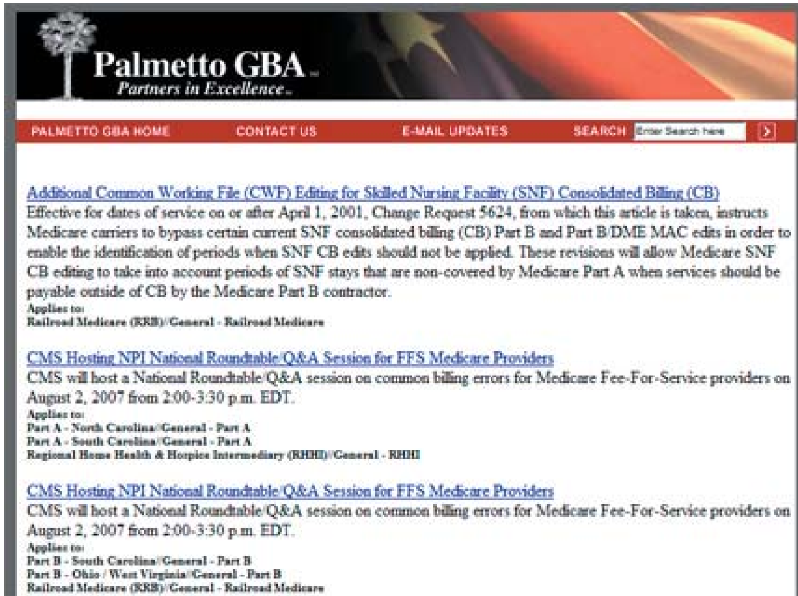

Additional Common Working File (CWF) Editing for Skilled Nursing Facility (SNF) Consolidated Billing (CB)
Effective for dates of service on or after April 1, 2001, Change Request 5624, from which this article is taken, instructs Medicare carriers to bypass certain current SNF consolidated billing (CB) Part B and Part B/DME MAC edits in order to enable the identification of periods when SNF CB edits should not be applied. These revisions will allow Medicare SNF CB editing to take into account periods of SNF stays that are non-covered by Medicare Part A when services should be payable outside of CB by the Medicare Part B contractor.
Applies to:
Railroad Medicare (RRB)//General - Railroad Medicare

CMS Hosting NPI National Roundtable/Q&A Session for FFS Medicare Providers
CMS will host a National Roundtable/Q&A session on common billing errors for Medicare Fee-For-Service providers on August 2, 2007 from 2:00-3:30 p.m. EDT.
Applies to:
Part A - North Carolina//General - Part A
Part A - South Carolina//General - Part A
Regional Home Health & Hospice Intermediary (RHHI)//General - RHHI

CMS Hosting NPI National Roundtable/Q&A Session for FFS Medicare Providers
CMS will host a National Roundtable/Q&A session on common billing errors for Medicare Fee-For-Service providers on August 2, 2007 from 2:00-3:30 p.m. EDT.
Applies to:
Part B - South Carolina//General - Part B
Part B - Ohio / West Virginia//General - Part B
Railroad Medicare (RRB)//General - Railroad Medicare

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Provider List Serv Registration Form

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

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

What is needed to receive updates?

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

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

FAX the completed form to (614) 473-6812

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

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

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

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Nurse Practitioner (NP) Services and Clinical Nurse Specialist (CNS) Services

Provider Types Affected

Nurse practitioners (NP) and clinical nurse specialist (CNS) who bill Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for services provided to Medicare Beneficiaries.

What You Need to Know

In CR 5639, from which this article is taken, the Centers for Medicare & Medicaid Services (CMS) announces that their manuals are being updated by adding the National Board on Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs. This list will also provide the new name for the National Certification Board of Pediatric Nurse Practitioners and Nurses and provide the correct reference for the Critical Care Certification Corporation. This same list of recognized national certifying bodies for advanced practice nurses will be included under the manual instruction on CNS services.

Carriers and A/B MACs will enroll nurses, under the NP and CNS benefits, who meet all of the other NP or CNS qualifications; and are certified as advanced practice nurses by any of the recognized national certifying bodies listed below, effective November 19, 2007.

Background

Federal regulations that govern nurse practitioner (NP) services at 42 CFR 410.75 and those governing the clinical nurse specialists (CNS) services at 42 CFR 410.76 require that these advanced practice nurses be certified by a national certifying body that has established standards for NPs and CNSs.

CR 5639, from which this article is taken, announces that CMS is adding the National Board on Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs at the advanced practice level, located in the ***Medicare Benefit Policy Manual,*** Chapter 15 (Covered Medical and Other Health Services), Section 200 (Nurse Practitioner (NP) Services). CR 5639 also announces the addition of this same list of recognized national certifying bodies for advanced practice CNSs in Section 210 (Clinical Nurse Specialist (CNS) Services) and in Chapter 10, Sections 12.4.5 and 12.4.8 of the ***Medicare Program Integrity Manual***.

Effective November 19, 2007, the list of recognized national certifying bodies for NPs and CNSs at the advanced practice level is as follows:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;

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- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

Additional Information

You can find more information about NP and CNS services by going to CR 5639, which is in two transmittals located on the CMS Web site. As an attachment to transmittal R75BP (http://www.cms.hhs.gov/Transmittals/downloads/R75BP.pdf), you will find updated ***Medicare Benefit Policy*** manual, Chapter 15 (Covered Medical and Other Health Services), Sections 200 (Nurse Practitioner (NP) Services) and 210 (Clinical Nurse Specialist (CNS) Services). As an attachment to transmittal R219PI (http://www.cms.hhs.gov/Transmittals/downloads/R219PI.pdf), you will find updated Chapter 10, Sections 12.4.5 and 12.4.8 of the ***Medicare Program Integrity Manual***.

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

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2008 Vaccine Administrations: Important Notice

Note: This article was revised on August 3, 2007, to correct the G code for the administration of vaccinations for Part D on page 2. The G HCPCS code referenced was G3077 and it should have been HCPCS code G0377. Also, a reference to a related article (SE 0727) was added in the Additional Information section. All other information is unchanged.

What Providers Need to Know

This article (Special Edition (SE) 0723) provides 2008 payment guidance for the administration of Part D-covered vaccines. This is not new policy guidance, just a reminder of the policy for 2008. **Remember that, effective January 1, 2008, physicians can no longer bill Medicare Part B for the administration of Medicare Part D-covered vaccines, using the special G HCPCS code (G0377).** Instead, you will need to bill the patient for the vaccine and its administration, and the patient will need to submit the claim to their Part D plan for reimbursement

You should make sure that your billing staffs are aware of this Part D-covered vaccine administration guidance for 2008.

Background

Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that, effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part D statute.

During 2007, in transition to this new policy, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G HCPCS code (G0377). SE 0723 now reminds providers of the requirement that payment for the administration of Part D covered vaccines only during 2007.

Therefore, effective January 1, 2008, you can no longer bill the G code to Part B; rather you will need to bill the patient for the vaccine and its administration, and the patient will need to submit the claim to the Part D plan for reimbursement.

Important Note: This guidance does not affect Part B covered vaccines.

Additional Information

You might want to look at MLN Matters articles MM 5486 (Payment by DME MACs and DMERCs for the Administration of Part D Vaccines), released December 29, 2006; and MM 5459 (Emergency Update to the 2007 Medicare Physician Fee Schedule Database (MPFSDB)) released January 11, 2007.

You can find these articles at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5486.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf, respectively. You may also want to review SE 0727 (Reimbursement for Vaccines and Vaccine Administration under Medicare Part D), which may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0727.pdf.

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

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Ambulance Services: Revision to Certification for Hospital Services

Background

CR 5684 furnishes the revised Certification for Hospital Services by the Supplementary Medical Insurance Program as those requirements pertain to physician certification of ambulance services in Chapter 4, Section 20 of the *Medicare General Information, Eligibility, and Entitlement Manual.*

Key Points of CR 5684

- Prior to the effective date (September 17, 2007) of CR 5684, certification by a physician in connection with ambulance services furnished by a participating hospital was required.
- As of the effective date of CR 5684, language requiring physician certification for ambulance services furnished by a participating hospital is deleted from the above mentioned Medicare manual.
- Your Medicare FI, Carrier or A/B MAC has been instructed to comply with this revision.

Additional Information

To view the official instruction (CR 5684) issued to Palmetto GBA, visit http://www.cms.hhs.gov/Transmittals/downloads/R47GI.pdf. The revised manual section is attached to CR 5684.

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

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Denying Separately Billed Services: Ambulance Remark Code

Provider Action Needed

Be aware that Palmetto GBA 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/R1318CP.pdf.

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

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Paravertebral Facet Joint Block: Coding Guidelines

Effective Date: July 16, 2007
The following coding guidelines are specific to the Paravertebral Facet Joint Block LCD:

CPT codes 64470 - 64476

- CPT codes 64470-64476 must not be used for local anesthesia during surgical procedures.
  - Local anesthesia by the surgeon is included in the surgical procedure.
- CPT codes 64470 or 64475 must be used to bill for the first vertebral level blocked.
- Only one unit of CPT code 64470 or 64475 may be submitted for a date of service.
- CPT codes 64472 or 64476 must be submitted for all additional levels blocked.
  - Up to two units of CPT code 64472 or 64476 may be submitted for a date of service.
  - These are add-on codes and must be submitted in additional to CPT codes 64470 or 64475, respectively.
- Only one unit per CPT code is allowed regardless of the number of pharmacologic agents injected at the same site; e.g., steroids and anesthetics.
- CPT modifier 50 (bilateral procedure) MUST be included with the appropriate CPT code(s) for any level to denote that BILATERAL blocks were performed at that level.
  - If CPT modifier 50 is not appended to denote bilateral, the service(s) will be considered and paid as unilateral.
- HCPCS modifier LT (left) or RT (right) may be used with the appropriate CPT code(s) for any level to denote that unilateral blocks were performed at that level.
- CPT modifier 76 should be appended to denote that a service was repeated by the same physician. This modifier indicates the difference between duplicate services and repeated services.
- CPT code 77003 is submitted for fluoroscopic guidance and localization of needle placement performed in conjunction with CPT codes 64470-64476.
- Injecting any substance through the needles including small amounts of contrast to confirm the position of the needle is an integral part of the procedure and it is not reimbursed separately.
- When destruction of the facet joint nerve is performed on the same date of service following the block, only the code for nerve destruction will be allowed.
  - The facet nerve block procedure is included in the facet nerve destruction.

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Anesthesia Services Furnished by the Same Physician Providing Medical & Surgical Services

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, which 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:

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

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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 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

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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 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.

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/R1316CP.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.

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Radiation Oncology Coding Guidelines

Effective: August 1, 2007

The following coding guidelines are specific to the Radiation Oncology LCD:

Tumor Mapping and Clinical Treatment Planning (CPT codes 77261-77263)

- Submit CPT code 77261 when the volume to be treated is clearly defined and easily encompasses the tumor (excludes normal tissue and structures.)
  - Simple planning requires no interpretation of special tests and involves no more than one critical structure.
- Submit CPT code 77262 to report a moderate level of planning difficulty involved and two separate volumes of interest (non-contiguous).
  - Critical or sensitive organs, which need protection usually, are involved.
  - Interpretation of special tests, localization of tumor volume, and not more than two critical structures are involved when planning the optimum course of treatment.
- Submit CPT code 77263 to report complex treatment planning is involved.
  - Three or more volumes of interest may require treatment.
  - Planning includes interpreting complex tests such as MR and/or CT localization of tumor(s).
  - The cancer is generally complex in its distribution regardless of whether the patient is in early or advanced stages of cancer.
  - Multiple critical areas generally require planning of special protection.
  - Combined therapy may be required for optimum benefit such as brachytherapy, surgery, and chemotherapy.

Therapeutic Radiology Simulation – Aided Field Setting (CPT codes 77280, 77285, 77290 and 77295)

- CPT code 77295 includes simulation procedures done in preparation for use of coplanar therapy beams and an additional simulation charge (CPT codes 77280, 77285, and 77290) is not separately payable on the same date.
- CPT code 77295 includes the work done for a teletherapy isodose plan and CPT codes 77305-77315 must not be submitted as separate procedures.
- CPT code 77295 may be billed once per treatment course per treatment volume.

Teletherapy Isodose Plan (CPT codes 77305, 77310 and 77315)

- Use CPT code 77305 to report one or two ports directed at one volume of interest.
- Use CPT code 77310 when there are three or more ports converging on a single volume of interest. Blocking may be utilized to eliminate the beam from certain portions of the isodose plan and must be verified.
- Use CPT code 77315 to report when five or more ports converge on a single volume of interest or when complex blocking and/or wedges are used with any port arrangement.
- Three-dimensional stereotactic isodose planning can be classified as a complex level isodose plan and may be submitted with CPT code 77315, or as part of CPT code 77295, but not with both.

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Special Teletherapy Port Plan (CPT code 77321)

- Submit only one teletherapy port plan per volume of interest.

Brachytherapy Isodose Calculation (CPT codes 77326-77328)

- It is a generally accepted standard of practice for CPT codes 77326-77328 to be submitted once per application. This procedure may be repeated only if a new implant is inserted.
- Use CPT code 77327 for multiplane calculations on the same day.

Treatment Devices, Designs, and Construction (CPT codes 77332-77334)

- Submit claims for devices at the beginning of the treatment course and then submit again later in the course of treatment when additional or new devices are required. Payment for one set of treatment devices may be allowed per separate port when radiation therapy is started. However, for billing purposes, a pair of opposing ports, ports that direct parallel beams such as anterior-posterior or left lateral-right lateral pairs are considered, to be one port. This is true regardless of the level of complexity used to create the ports. However, if these devices are significantly different from each other, then the carrier may allow payment for each of the pair of devices. It is the responsibility of the provider to determine the CPT code that most accurately describes the devices employed. At all levels of complexity, the physician must be directly involved in the design, selection, and placement of any of the devices.
- Submit custom-made immobilization devices at a complex level (CPT code 77334). Samples include, but are not all-inclusive to restraining devices such as aquaplast and alpha cradle.
- Submit a combination of a wedge, a compensator, a bolus, or a port block covering the same treatment portal, as a single complex treatment device charge rather than a separate charge rendered for each of the individual items. If devices of two separate levels of complexity are utilized for the same treatment portal, only submit a claim for the one of highest complexity.
- For treatment devices, designs, and construction (CPT codes 77332-77334), the number of different anatomic sites determines the number of sets or ports involved. Opposing fields (such as AP/PA) represent one set. Each set must be submitted on a claim with the appropriate level of complexity at the onset of therapy.

Medical Radiation Physics Consultation (CPT codes 77336 and 77370)

- CPT codes 77336 & 77370 only represent technical services and are payable by Medicare Part B only in settings in which the technical component is payable, i.e., in the freestanding radiation oncology center that employs its own radiation physicist.

Stereotactic Radiation Treatment Delivery (CPT codes 77371-77373)

- Use CPT codes 77371 or 77372 to report stereotactic radiosurgery (SRS) delivery for the treatment of cerebral lesion(s). A team consisting of the radiation oncologist, neurosurgeon and medical physicist is responsible for supervising the patient positioning and proper alignment of treatment beams involved in SRS. CPT code 77432 should be included when reporting either CPT code 77371 or 77372.
- Use CPT code 77373 to report stereotactic body radiation therapy (SBRT) treatment delivery per fraction (not to exceed 5 fractions). Do not report CPT code 77373 in conjunction with CPT codes 77401-77416 and 77418.

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- Use CPT codes 77371 or 77372 to report the technical component of the single-fraction cranial SRS complete course of treatment in one session for the two SRS technical modalities utilized.

Radiation Treatment Delivery (CPT codes 77401-77416, 77418, 77421 and 0073T)
- Report radiation treatment delivery according to the level of service and the energy used.
- Radiation treatment delivery may be submitted using a date range if the treatments are performed on consecutive days and the energy and level of service are the same. Indicate the total treatment number in the CMS-1500 claim form days/units field.
- If the dates of service are not consecutive or the energy or level of service is not the same, each date of service must be submitted on a separate detail line.
- When more than one treatment is performed on the same day, e.g., hyperfractionation, each treatment should be submitted on a separate detail line.
- Multiple treatment sessions on the same day are payable as long as there has been a distinct break in therapy services and the individual sessions are of the character usually furnished on different days. When submitting a claim for multiple treatments on the same day, the claim must document a distinct break between therapy. Statements such as “A.M. and P.M. treatments” suffice.
- Use CPT code 0073T for compensatory-based beam modulation treatment delivery.
- Do not report CPT code 0073T in conjunction with CPT codes 77401-77416 or 77418.

Portal Verification Film(s) (CPT code 77417)
- Use CPT code 77417 to report port verification films or electronically generated portal images. These images should agree with the original simulation films and dosimetry. CPT code 77417 must be submitted with a quantity billed of one.
- Portal verification films should be reported as one charge per five fractions of therapy, regardless of the number of films required during this time interval or the number of ports involved. If at the end of a treatment course, three or four fractions remain, then one unit of portal verification will be reimbursed. If only one or two fractions remain, then no reimbursement will be made.

Radiation Treatment Management (CPT codes 77427, 77431, 77432 and 77435)
- Report radiation treatment management in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days.
- The date of service must be the beginning date for each unit of five fractions. Do not submit a span of days.
- The quantity billed must be submitted as one for each five fractions. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and fractions are of the character usually furnished on different days.
- CPT code 77427 may also be reported with a quantity of one when there are three or four fractions remaining at the end of a course of treatment. One or two fractions remaining at the end of a course of treatment are not to be reported.

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- CPT code 77431 is to be used only if a patient's entire treatment course consists of only one or two fractions.
- Submit CPT code 77431 with the quantity billed regardless if one or two fractions are used.
- CPT code 77435 and 77421 should not be reported together.

Special Treatment Procedure (CPT code 77470)

- It is considered acceptable standards of practice for CPT code 77470 to be reported only once during a treatment course and may be submitted with the weekly management codes.
- For the remaining treatment course, a physician should use the appropriate weekly radiation therapy management codes.
- If the treatment course is modified for any reason, use the appropriate CPT code for the simulation field-setting and dosimetry. CPT code 77470 should not be used to indicate a modified treatment course.

High-dose rate (HDR) Brachytherapy (CPT codes 77781-77784)

- Select the appropriate code based on the number of source positions or catheters used in the treatment.
- Use CPT code 77781 to report one to four of source positions or catheters.
- Use CPT code 77782 to report five to eight of source positions or catheters.
- Use CPT code 77783 to report nine to 12 of source positions or catheters.
- Use CPT code 77784 to report more than 12 of source positions or catheters.
- The technical component of these CPT codes includes the cost for the radiopharmaceutical.
- Radiation treatment management (CPT code 77427) may be reported every fifth treatment with remote afterloading brachytherapy (HDR) if it is the sole modality of treatment and used on a daily basis the same as conventional radiation treatment.

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Laboratory Specimens: Service Dates

Provider Action Needed

This article is based on Change Request (CR) 5573 which implements revisions to the date of service (DOS) policy for tests performed on laboratory specimens, in accordance with updates to 42CFR414.510 that were published in the Federal Register on December 1, 2006.

- **Remember when submitting claims that the general rule is that the date of service is the date the specimen is collected.**
- **Where a specimen is collected over a period that spans two calendar days, the date of service is the date the collection period ended.**

Background

The general rule for the date of service (DOS) of a test performed on a laboratory specimen is the date that the specimen is collected. If a specimen is collected over a period that spans two calendar days, then the DOS must be the date that the collection period ended.

The current DOS policy allows an exception to the general rule for tests performed on an archived specimen. If a specimen was stored for more than 30 calendar days before testing (otherwise known as "an archived specimen"), the DOS of the test must be the date that the specimen was obtained from storage.

In the final physician fee schedule regulation published in the Federal Register on December 1, 2006 (http://www.access.gpo.gov/su_docs/fedreg/a061201c.html), the Centers for Medicare & Medicaid Services (CMS) revised the DOS policy for laboratory specimens to allow additional exceptions to the general rule and the DOS rule for tests performed on an archived specimen.

CR 5573 implements the revisions to the DOS policy for tests performed on laboratory specimens specified in the final rule, in accordance with the updates to 42 CFR §414.510 (http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/06-9086.htm).

As already mentioned, under the revised DOS policy for laboratory specimens, the **General Rule** is that the DOS of the test must be the date the specimen was collected. However, there is a **variation:** If a specimen is collected over a period that spans two calendar days, then the DOS must be the date the collection ended.

The following exceptions apply to the DOS policy for laboratory tests:

DOS for Tests Performed on Stored Specimens:

In the case of a test performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, **the DOS of the test must be the date the test was performed only if:**

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- The test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;

- The specimen was collected while the patient was undergoing a hospital surgical procedure;

- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;

- The results of the test do not guide treatment provided during the hospital stay; and

- The test was reasonable and medically necessary for treatment of an illness.

Note: If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived, and the DOS of the test must be the date the specimen was obtained from storage.

DOS for Chemotherapy Sensitivity Tests Performed on Live Tissue:

In the case of a chemotherapy sensitivity test performed on live tissue, **the DOS of the test must be the date the test was performed only if**:

- The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge;

- The specimen was collected while the patient was undergoing a hospital surgical procedure;

- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;

- The results of the test do not guide treatment provided during the hospital stay; and

- The test was reasonable and medically necessary for treatment of an illness.

Note: For purposes of applying the above exception, a "chemotherapy sensitivity test" is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents.

Additional Information

The official instruction, CR 5573, issued to Palmetto GBA regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1319CP.pdf.

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

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Astigmatism-Correcting Intraocular Lens (A-C IOLs): CMS Ruling CMS 1536-R

Note: This article was revised on July 18, 2007, to provide new Web addresses for accessing the Notices of Exclusion from Medicare Benefits. All other information remains the same.

Provider Action Needed

This article is based on Change Request (CR) 5527 which discusses a recent Administrator Ruling from the Centers for Medicare & Medicaid Services (CMS) regarding astigmatism-correcting intraocular lenses (A-C IOLs) following cataract surgery (CMS-1536-R). **The new policy is effective for dates of service on and after January 22, 2007. Physicians and providers need to be aware that effective January 22, 2007:**

- Medicare will pay the same amount for cataract extraction with A-C IOL insertion that it pays for cataract extraction with conventional IOL insertion.
- **The beneficiary is responsible for payment of that portion of the hospital or ambulatory surgery center (ASC) charge for the procedure that exceeds the facility's usual charge for cataract extraction and insertion of a conventional IOL following cataract surgery, as well as any fees that exceed the physician's usual charge to perform a cataract extraction with insertion of a conventional IOL.**
- In addition, CMS reminds physicians that they can be reimbursed for the conventional or A-C IOL (HCPCS code V2632) only when the service is performed in a physician's office. Also, when physicians perform cataract surgery in an ASC or hospital outpatient setting, the physician may only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.

Background

The Centers for Medicare & Medicaid Services (CMS) Administrator rulings serve as 1) precedent final opinions and orders and 2) statements of policy and interpretation. The Administrator rulings provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, utilization and peer review by Quality Improvement Organizations, private health insurance, and related matters. These rulings also promote consistency in interpretation of policy and adjudication of disputes, and they are binding on all CMS components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and Administrative Law Judges who hear Medicare appeals.

CR 5527 discusses a recent CMS Administrator Ruling concerning requirements for determining payment for insertion of intraocular lenses (IOLs) that replace beneficiaries' natural lenses and correct pre-existing astigmatism following cataract surgery under the Social Security Act.

Note that CR 5527 basically restates CMS policy provided in CR 3927 (*MLN Matters* article MM3927), except that CR 3927 focused on presbyopia-correcting IOLs and this article focuses on A-C IOLs.

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Coverage Policy

In general, an item or service covered by Medicare must satisfy the following three basic requirements:

- Fall within a statutorily-defined benefit category;
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part;
- Not be excluded from coverage.

The Social Security Act specifically excludes eyeglasses and contact lenses from coverage, with an exception for one pair of eyeglasses or contact lenses covered as a prosthetic device furnished after each cataract surgery with insertion of an IOL. In addition, there is no Medicare benefit category to allow payment for the surgical correction or cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for the imperfect curvature of the cornea (astigmatism).

An A-C IOL is intended to provide what is otherwise achieved by two separate items:

- An implantable conventional IOL (one that is not astigmatism -correcting) that is covered by Medicare, and
- The surgical correction, eyeglasses, or contact lenses that are not covered by Medicare.

Although A-C IOLs may serve the same function as eyeglasses or contact lenses furnished following removal of a cataract, A-C IOLs are neither eyeglasses nor contact lenses. The following table is a summary of benefits for which Medicare makes payment, and services for which Medicare does not pay (no benefit category):

Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
A conventional intraocular lens (IOL) implanted following cataract surgery.	The astigmatism-correcting functionality of an IOL implanted following cataract surgery.
Facility or physician services and supplies required to insert a conventional IOL following cataract surgery.	Facility or physician services and resources required to insert and adjust an AC-IOL following cataract surgery that exceeds the services and resources furnished for insertion of a conventional IOL.
One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.	The surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for imperfect curvature of the cornea (astigmatism)

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Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
	Eye examinations performed to determine the refractive state of the eyes specifically associated with insertion of an AC-IOL (including subsequent monitoring services), that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.

Currently, there is one NTIOL class approved for special payment when furnished by an ASC, and this currently active NTIOL category for "Reduced Spherical Aberration" was established February 27, 2006, and expires on February 26, 2011.

Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as A-C IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc; and
- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

Payment Policy for Facility Services and Supplies

The following applies to an IOL inserted following removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under 1) the hospital Outpatient Prospective Payment System (OPPS) or 2) the Inpatient Prospective Payment System (IPPS), respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- Medicare does not make separate payment to the hospital or the ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure; and
- Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.

For an A-C IOL inserted subsequent to removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under the OPPS or the IPPS, respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- The facility should bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or A-C IOL is inserted. When a beneficiary receives an A-C IOL following removal of a cataract, hospitals and ASCs should report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see "Coding" below);

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- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL; and
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives an AC-IOL following removal of a cataract that exceed the facility charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

Payment Policy for Physician Services and Supplies

For an IOL inserted following removal of a cataract in a physician's office Medicare makes separate payment, based on reasonable charges, for an IOL inserted subsequent to extraction of a cataract that is performed at a physician's office.

For an A-C IOL inserted following removal of a cataract in a physician's office:

- A physician should bill for a conventional IOL, regardless of whether a conventional or A-C IOL is inserted (see "Coding," below);
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL; and
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an AC-IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

For an A-C IOL inserted following removal of a cataract in a hospital or ASC:

- A physician may not bill Medicare for the A-C IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure;
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL; and
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an A-C IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary following cataract surgery with insertion of a conventional IOL.

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Coding

No new codes are being established at this time to identify an A-C IOL or procedures and services related to an A-C IOL, and hospitals, ASCs, and physicians should report one of the following CPT codes to bill Medicare for removal of a cataract with IOL insertion:

- CPT Code 66982 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage,
- CPT Code 66983 - Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure), or
- CPT Code 66984 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).

Physicians inserting an IOL or an A-C IOL in an office setting may bill HCPCS code V2632 (posterior chamber intraocular lens) for the IOL or the A-C IOL, which is paid on a reasonable charge basis.

If appropriate, hospitals and physicians may use the proper CPT code(s) to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

Beneficiary Liability

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility charges for services and supplies attributable to the astigmatism-correcting functionality of the A-C IOL:

- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the AC-IOL that exceeds the work and resources attributable to insertion of a conventional IOL;
- The physician and the facility may not charge for cataract extraction with insertion of an A-C IOL unless the beneficiary requests this service; and
- The physician and the facility may not require the beneficiary to request an A-C IOL as a condition of performing a cataract extraction with IOL insertion.

Provider Notification Requirements

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract:

Prior to the procedure to remove a cataractous lens and insert an A-C IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the

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insertion, adjustment, or other subsequent treatments related to the astigmatism-correcting functionality of the IOL.

The correcting functionality of an A-C IOL does not fall into a Medicare benefit category and, therefore, is not covered. Therefore, the facility and physician are not required to provide an Advanced Beneficiary Notice to beneficiaries who request an A-C IOL.

Although not required, CMS strongly encourages facilities and physicians to issue a **Notice of Exclusion from Medicare Benefits** to beneficiaries in order to identify clearly the non-payable aspects of an A-C IOL insertion. This notice may be found on the CMS Web site at:

- http://www.cms.hhs.gov/BNI/downloads/CMS20007English.pdf for the English language version and
- http://www.cms.hhs.gov/BNI/downloads/CMS20007Spanish.pdf for the Spanish language version.

Additional Information

The official instruction, CR 5527, issued to your Medicare carrier, intermediary, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1228CP.pdf.

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

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Endothelial Keratoplasty

Effective: August 1, 2007

This updates the previous article published on May 1, 2007.

Descemet's stripping, endothelial keratoplasty and deep lamellar endothelial keratoplasty involve the stripping of diseased corneal endothelium and the placement of intraocular endothelium harvested from a donor.

According to the American Academy of Ophthalmology, the physician work allowance for each of the three penetrating keratoplasty codes is similar to endothelial keratoplasty.

Until a Category I CPT code is established to describe this procedure, please submit the following effective August 1, 2007:

CPT code 66999 (unlisted procedure, anterior segment of the eye)

- Enter into the narrative field: "Endothelial transplant" followed by the appropriate crosswalk (CPT code 65730, 65750, 65755) based on the patient's lens status.
    - Example: "Endothelial transplant - 65750"

If the surgeon performs an endothelial transplant service AND harvests the endothelial tissue from a donor eye, submit the following information:

CPT code 66999 (unlisted procedure, anterior segment of the eye)

- Enter into the narrative field: "Endothelial **harvest** - transplant" followed by the appropriate crosswalk (CPT code 65730, 65750, 65755) based on the patient's lens status.
    - Example: "Endothelial harvest transplant - 65750"

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Screening Mammography Claims: Correct Reporting of Diagnosis Codes

This article was revised on July 27, 2007, to add a reference to CR 5377. MM 5050 erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services (page 1) supplied to Medicare inpatients and billable under Medicare Part B. CR 5377 announced that effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACS as an appropriate bill type for such services.

Providers Action Needed

This article and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.

- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

In addition, CR 5050 updates Chapter 18; Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It **removes 12X type of bill (TOB)** from the list of applicable TOBs for diagnostic mammography; (**See Note above.**)

- It **adds HCPCS code G0202** to the list of valid codes for the billing of screening mammography; and

- It **adds HCPCS codes G0204 and G0206** to the list of valid codes for the billing of diagnostic mammographies.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

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Implementation

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

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf. The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR 5050.

To view the instruction (CR 5377) that reversed the removal of TOB 12x, visit http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf. The related MLN Matters article maybe found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf.

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PET Scans: Revised Coding Information

Impact to You

Effective for services on and after January 28, 2005, your carrier, FI, or A/B MAC will deny claims for PET Scan services that contain CPT code 78609 and they will deny claims for PET Scan services on or after January 1, 2008, that contain HCPCS code A4641.

What You Need to Know

CR 5665, from which this article is taken, corrects erroneous information that was originally issued in CR 3741, transmittal 527 (New Coding for FDG PET Scans and Billing Requirements for Specific Indications of Cervical Cancer), dated April 15, 2005. CR 5665 updates *Medicare Claims Processing Manual,* Chapter 13, Sections 60.30.1 and 60.30.2 by removing CPT code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans.

What You Need to Do

Make sure that your billing staffs are aware of these code changes and submit only covered codes in your claims for PET Scan services.

Background

The Centers for Medicare & Medicaid Services (CMS) recently learned that the *Medicare Claims Processing Manual,* Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans), and CR 3747 (transmittal 527, dated April 15, 2005), contain incorrect information regarding CPT code 78609 (PET for brain perfusion imaging) and HCPCS code A4641.

In Section 60.3.1, CPT code 78609 is incorrectly listed as a covered service by Medicare, and in Section 60.3.2 is incorrectly included in terms of the applicability of certain tracer codes. Similarly, Section 60.30.2 incorrectly lists HCPCS code A4641as an applicable tracer for PET Scans.

CR 5665, from which this article is taken, corrects these errors. It updates the manual by removing CPT code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans. In so doing, it also corrects correct the erroneous information that was originally issued in CR 3747.

Notes:

1) ***All Positron Emission Tomography (PET) Scans services (CPT codes 78459, 78491, 78492, 78608, and 78811-78816) require the use of a radiopharmaceutical diagnostic imaging agent (tracer). Therefore, the applicable tracer code should always be used when billing for a PET scan service.***

2) ***The correct PET Scan CPT codes and tracer HCPCS codes are listed in Tables 1 and 2.***

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Key points in CR 5665

- Effective January 28, 2005, CPT 78609 became a non-covered service for Medicare;
- Carriers, FIs, and A/B MACS will deny claims submitted with CPT code 78609 (effective January 28, 2005);

When denying these claims, they will use:

- Medicare Summary Notice (MSN) 16.10 "Medicare does not pay for this item or service."
- Claim Adjustment Reason Code 96: "Non-covered charge."
- Remittance Advice Remark Codes 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."

Effective January 1, 2008, HCPCS code A4641 is not an applicable tracer for PET Scans;

- You should not report HCPCS code A4641 when submitting claims for PET Scans for services on or after January 1, 2008. At that time when submitting claims for PET Scans containing CPT code 78491 or 78492 you should use only tracer HCPCS codes A9555 or A9526; and, when submitting claims for PET Scans containing CPT codes 78459, 78608, or 78811-78816, you should use only tracer HCPCS code A9552 (see table 2, below).
- Carriers, FIs, and A/B MACs will not search for, and adjust, claims that have been paid prior to the implementation date, but they will adjust claims brought to their attention.

The following tables list the currently covered PET Scan CPT codes (on or after January 28, 2005) and tracer HCPCS codes, as of January 1, 2008).

Table 1
Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005

CPT Code	Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress

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CPT Code	Description
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78811	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body
NOTE: All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See Table 2, below, for applicable tracer codes.	

Table 2
Tracer Codes Required for PET Scans on or after January 1, 2008 (HCPCS code A4641 is allowed for services on or before December 31, 2007)

The following tracer* codes are applicable *only* to CPT codes 78491 and 78492. *They cannot be reported with any other code.	
Institutional providers billing fiscal intermediaries or A/B MACs	
HCPCS Code	**Description**
*A9555	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82, Diagnostic, Per study dose, Up To 60 Millicuries
*Q3000 (Deleted effective 12/31/05)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13

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<table>
<tr><td colspan="2">*NOTE: For claims with dates of service prior to January 1, 2006, providers report HCPCS code Q3000 for supply of radiopharmaceutical diagnostic imaging agent, Rubidium Rb-82. For claims with dates of service January 1, 2006, and later, providers report HCPCS code A9555 for radiopharmaceutical diagnostic imaging agent, Rubidium Rb-82 in place of HCPCS code Q3000.</td></tr>
<tr><td colspan="2">Physicians/practitioners billing carriers or A/B MACs</td></tr>
<tr><td>*A4641</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified</td></tr>
<tr><td>A9526</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13</td></tr>
<tr><td>A9555</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82, Diagnostic, Per study dose, Up To 60 Millicuries</td></tr>
<tr><td colspan="2">*NOTE: Effective January 1, 2008, tracer HCPCS code A4641 is not applicable for PET Scans.</td></tr>
<tr><td colspan="2">The following tracer codes are applicable only to CPT 78459, 78608, 78811-78816. They cannot be reported with any other code:</td></tr>
<tr><td colspan="2">Institutional providers billing fiscal intermediaries or A/B MACs</td></tr>
<tr><td>*A9552</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries</td></tr>
<tr><td>*C1775 (Deleted effective 12/31/05)</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18</td></tr>
<tr><td>**A4641</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified</td></tr>
<tr><td colspan="2">*NOTE: For claims with dates of service prior to January 1, 2006, OPPS hospitals report HCPCS code C1775 for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18. For claims with dates of service January 1, 2006, and later, providers report HCPCS code A9552 for radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18 in place of HCPCS code C1775.
**NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.</td></tr>
<tr><td colspan="2">Physicians/practitioners billing carriers or A/B MACs</td></tr>
<tr><td>A9552</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries</td></tr>
<tr><td>*A4641</td><td>Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified</td></tr>
<tr><td colspan="2">*NOTE: Effective January 1, 2008, tracer HCPCS code A4641 is not applicable for PET Scans.</td></tr>
</table>

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Additional Information

You can find more information about PET Scan codes by going to CR 5665, located at http://www.cms.hhs.gov/Transmittals/downloads/R1301CP.pdf. You will find the updated *Medicare Claims Processing Manual,* Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans) as an attachment to that CR.

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Assistant Surgery, Co-Surgery, and Team Surgery: Modifier Required

If you participated as an assistant surgeon, co-surgeon, or team surgeon, you must add the appropriate modifier to the surgical procedure(s). Pay special attention to the descriptions of the modifiers to ensure you are submitting the one appropriate for your service.

HCPCS Modifier AS

Assistant Surgeon (Non-physician)

- Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist services who participated as an assistant to a surgeon
- Procedure codes that have an ASST 0 indicator on the MPFSDB must be submitted with supporting documentation.

CPT Modifier 62

Co-Surgeons (working together as primary surgeons)

- Surgeon who performed surgery(s) with another surgeon; both surgeons must add CPT Modifier 62 to the surgical procedure
- Procedure codes that have a CO-SURG 1 indicator on the MPFSDB must be submitted with supporting documentation.

CPT Modifier 66

Team Surgeons (for highly complex procedures; often requiring different physician specialties)

- Surgeon who performed surgery(s) with two or more other surgeons; all surgeons must add CPT Modifier 66 to the surgical procedure
- Procedure codes that have a TEAM 1 or 2 indicator on the MPFSDB must be submitted with supporting documentation.

CPT Modifier 80

Assistant Surgeon (Physician)

- Surgeon who participated as an assistant to a surgeon.
- Procedure codes that have an ASST 0 indicator on the MPFSDB must be submitted with supporting documentation.

CPT Modifier 81

Minimum Assistant Surgeon

- Surgeon who participated as an assistant to a surgeon.
- Procedure codes that have an ASST 0 indicator on the MPFSDB must be submitted with supporting documentation.

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CPT Modifier 82
Assistant Surgeon (when qualified resident surgeon not available)
- Surgeon who participated as an assistant to a surgeon.
- Procedure codes that have an ASST 0 indicator on the MPFSDB must be submitted with supporting documentation.

Check out the additional information and coding requirements for these modifiers on our Web site. Look for the **Modifier Lookup** link on our home page.
- Ohio – http://www.PalmettoGBA.com/boh
- West Virginia – http://www.PalmettoGBA.com/bwv

Refer to Sections 20.4.3, 40.8, 100.1.7, and 110 in the CMS Manual at http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf for more information regarding CMS's requirements for these modifiers.

Refer to CMS's MPFSDB Lookup link at http://www.cms.hhs.gov/PFSlookup/ to view the ASST, CO-SURG, and TEAM indicators assigned to procedure codes.

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Saturation Biopsy of Prostate

Effective date: August 1, 2007

Office based ultrasound guided transrectal needle biopsy is usually the initial procedure used to diagnose prostate cancer.

The sextant method of biopsy to obtain six cores is usually sufficiently accurate and avoids morbidity associated with more cores but may have a significant false-negative rate.

Saturation ultrasound guided transrectal needle biopsy under anesthesia, samples the entire gland, obtains up to 20 or more samples, and is useful in men at risk for prostate cancer with previous negative sextant biopsies performed in the office setting. This technique has an improved diagnostic yield as compared to repeated sextant biopsies, and will be covered by Palmetto GBA.

CPT code 0137T

- Biopsy, prostate, needle, saturation sampling for prostate mapping

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Temporary Prostatic Urethral Stent

Effective date: August 1, 2007

The FDA Center for Devices and Radiologic Health has approved the Spanner™ Temporary Prostatic Stent.

Palmetto GBA will cover the insertion of this device when used for up to a 30 day temporary use to maintain urine flow and allow voluntary urination in men following minimally invasive treatment for benign prostatic hypertrophy and after initial post-treatment catheterization.

CPT code 0084T

- Insertion of a temporary prostatic urethral stent

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Coverage of Skin Substitutes for Wound Healing

Effective Date: August 1, 2007

The Local Coverage Determination (LCD) limits coverage of skin substitutes to those that contain biologically active elements used for adjunctive treatment of wounds. HCPCS codes J7343, J7344, J7345 and J7346 describe devices "without biologically active elements" and are not payable.

To meet the HCPCS code descriptions for codes J7340, J7341 and J7342, the device must contain biologically active elements. Devices without biologically active elements and products labeled with indications for venous stasis or neuropathic diabetic ulcers that do NOT contain biologically active elements will be denied as "wound dressings".

Palmetto GBA considers wound dressings to be included in the wound care service of Evaluation and Management (E/M) service that day and will not be separately reimbursed. The dressings are considered a practice expense in the office setting. If debridement is not performed, wound dressing application claims must be submitted utilizing the appropriate E/M code. Submission of CPT codes 15340-15366 or 15430-15431 for application of a product or device that is not described by one of the HCPCS codes J7340-J7342 is inappropriate.

The following CPT codes are appropriately submitted for application of the skin substitute. CPT codes 15360-15366 and 15430-15431 carry a 90-day global period. Because the work value includes repeated applications usually performed during this time frame, it is inappropriate to use CPT modifier 58 (staged or related procedure or service by the same physician during the postoperative period).

1. CPT codes 15340-15341 are used for the application of cultured allogeneic skin with both a dermal and epidermal layer (e.g., Apligraf®). Use for application of HCPCS code J7340.

2. CPT codes 15360-15366 are used for application of cultured allogeneic neonatal dermal fibroblasts (e.g. Dermagraft®). Use for application of HCPCS code J7342.

3. CPT codes 15430-15431 are used for application of acellular xenograft tissue (e.g. Oasis®). Use for application of HCPCS code J7341.

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

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

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

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

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

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

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Local Coverage Determination Updates

LCD	Change	Effective Date
Erythropoiesis Stimulating Proteins for Patients Not On Dialysis 2002-1LR13	Retired	08/01/2007
Chemotherapy & Biologicals 2002-29LR30.4	Addition of HCPCS code J9999 for Torisel (Temsirolimus) for ICD-9 code 189.0. Addition of HCPCS code J3590 for Soliris (Eculizumab) for ICD-9 code 283.2. Addition of ICD-9 codes 202.00 - 202.08 as supporting medical necessity for Velcade (bortezomib), HCPCS code J9041.	08/01/2007

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Medicare Opt Out HPSA and/or PSA Bonus Program

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

Provider Name: ____

Practice or Business Name: ______________________________________

Address: ____

City, State, ZIP: ____

Phone Number (including area code): _____________________________

Identify All Applicable Medicare Provider Identification Numbers (PINs):

____

Signature: ____

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

* You may backdate this option, 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

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Redetermination Request for Medicare Part B Claims

For Ohio & West Virginia

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

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

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

General Information

*** Indicates required fields.**

*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: ____________________________

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

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MEDICARE
Part A Intermediary
Part B Carrier

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

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CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE
Part A Intermediary
Part B Carrier

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
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CMS Offers FREE Medicare Training for Providers

CMS Web Training

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

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

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

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

TTY 1-877-391-9739

Provider Enrollment Support Line
1-866-308-5439

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

Medicare Secondary Payer
1-866-308-5442

Telephone Reopenings
1-866-308-5441

Medicare Fraud Hotline
1-888-619-5316

Medicare Patient Call Center

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

TTY 1-877-486-2048

FREE Training Available

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

Palmetto GBA
4249 Easton Way
Columbus, OH 43219

http://www.PalmettoGBA.com

Important Sources For You

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

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

Attention: Billing Manager

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