



# Pinnacle Medicare Providers' News

*Serving the Medicare Part B Providers of  
Arkansas, Louisiana, Missouri, New Mexico,  
Oklahoma and Rhode Island*



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## Alert

# National Implementation of the Medicare Contractor Provider Satisfaction Survey (MCPSS) – Fact Sheet

Reference: JSM CI 3331-05505, 09-07-05

The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to measure provider satisfaction with and perceptions about the services provided by Medicare Fee-for-Service (FFS) Contractors. The MCPSS gives Medicare providers the opportunity to rate their Contractor(s) on seven business functions: provider communications, provider inquiries, claims processing, appeals, medical review, provider enrollment, and provider reimbursement. It also includes a scoring framework that will calculate a score (e.g., composite score by business functions and aggregate overall score) for each Contractor.

In 2005, the Centers for Medicare & Medicaid Services (CMS) conducted a pilot of the MCPSS to a sample of 8,200 Medicare FFS providers, approximately 2% of providers served by 12 selected Medicare FFS Contractors. CMS used the results of the pilot to evaluate and refine the survey instrument, data collection procedures, analysis, and reporting of results for the national survey implementation. The results of the pilot were not used to evaluate the pilot Contractors' performance.

**Provider Satisfaction is a top priority with Pinnacle Medicare Services. Your input is important to us!**

### Purpose:

The MCPSS has three main goals: (1) to satisfy the Medicare Modernization Act requirements for the measurement of provider satisfaction levels; (2) to support and assist Contractors in using provider feedback to identify and implement quality/process improvement initiatives; and (3) to establish provider satisfaction as a standard of measurement in performance-based/incentive contracting.

### National Implementation:

CMS will administer its first national implementation of the MCPSS in January 2006. The national implementation will include all Medicare FFS Contractors, including Fiscal Intermediaries (FIs), Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Regional Home Health Intermediaries (RHHIs). The survey will be sent to a sample of approximately 30,000 Medicare providers and suppliers. Sampled providers/suppliers will have the opportunity to submit their responses via a secure Internet website, or may request a paper copy of the survey instrument and submit their responses via mail or fax.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS. Westat will be responsible for all aspects of the survey administration, including printing and mailing the survey materials, processing all completed surveys, analyzing the data, and reporting the results. To view the MCPSS Study web site, please visit [www.mcpsstudy.org](http://www.mcpsstudy.org).

### Status:

CMS has requested clearance from the Office of Management and Budget (OMB) for the MCPSS national implementation. To obtain copies of the supporting statement and any related forms, you may access CMS' Paperwork Reduction Act website at <http://new.cms.hhs.gov/PaperworkReductionActof1995/>.

### Projected Timeline:

National Administration- January 2006  
Contractor Reports - June 2006  
Final Reports - July 2006

**FOR FURTHER INFORMATION & UPDATES, LOG ONTO:** <http://www.cms.hhs.gov/MCPSS/>

### Contacts:

#### CMS:

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#### Westat:

Vasudha Narayanan or Terita Jackson, 1-888-863-3561, [MCPSS@westat.com](mailto:MCPSS@westat.com)

## *Ambulance*

### **Collection and Verification of Ambulance Crew Member Information**

*Reference: Medlearn Matters Number: SE0610*

#### ***Provider Types Affected***

Providers and suppliers who bill Medicare carriers for ambulance services

#### ***Key Points***

- Effective February 9, 2006, the Centers for Medicare & Medicaid Services (CMS) will no longer require enrolled ambulance suppliers to report crew member changes in Attachment 1 of the provider enrollment application CMS-855B.
- This policy change only applies to ambulance companies already enrolled with Medicare.
- Ambulance suppliers that are enrolling in the Medicare program for the first time or are submitting a new enrollment application are required to report ambulance crew member information in Attachment 1 of the provider enrollment application (CMS-855B).
- This change should reduce the paperwork burden imposed on ambulance suppliers and reduce the number of ambulance supplier changes processed by contractors.

#### ***Background***

On January 27, 2006, CMS published a Federal Register notice requesting public comments on revisions to the provider enrollment applications.

While CMS is seeking comments regarding proposed changes to its Medicare enrollment applications, it is also adopting a policy change that affects ambulance suppliers effective immediately with regard to reporting crew member information as noted above.

#### ***Relevant Links***

The Medicare Federal Health Care Provider/Supplier Enrollment Application Form CMS-855B can be found on the CMS web site at:

<http://new.cms.hhs.gov/MedicareProviderSupEnroll/downloads/cms855b.pdf>

If you have any questions regarding this issue, contact your carrier at their toll free number, which is available on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## Appeals

### Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date May 1, 2005)

Reference: Trans. 697, CR #3942, Pub. 100-04, Medlearn Matters Number: MM3942

**Note:** This article was revised on February 21, 2006, to update the language regarding the appeals process. In addition, the article now contains web addresses that conform to the new CMS website.

#### Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare for services

#### Impact to You

The new second level in the administrative appeals process is called a “**reconsideration**.” Reconsiderations are processed by Qualified Independent Contractors (QICs).

#### Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called a reconsideration.

Requests for reconsideration of appeal decisions (redeterminations) should go either to the Qualified Independent Contractor (QIC), or the Hearing Officer (HO), when the redetermination was issued by a carrier prior to January 1, 2006.

#### Time Limit for Filing a Request for Reconsideration

A request for reconsideration must be filed within 180 days of the date of receipt of the notice of redetermination. For requests filed in writing - the date received is defined as the date received by the QIC in the corporate mailroom.

Please refer to the following table for clarification.

#### Appeal Rights for Requests for Reconsideration The Second Level of Appeal

| Medicare Claims | Medicare Contractor Issuing Redetermination | Date Redetermination Issued and Mailed | Where to Appeal the Redetermination* |
|-----------------|---|--|--------------------------------------|
| Part A/Part B   | FI  | On or after May 1, 2005                | QIC                                  |
| Part B          | Carrier                                     | On or after January 1, 2006            | QIC                                  |
| Part A          | FI  | Before May 1, 2005                     | ALJ                                  |
| Part B          | FI  | Before May 1, 2005                     | HO                                   |
| Part B          | Carrier                                     | Before January 1, 2006                 | HO                                   |

\* Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ); Hearing Officer (HO)

#### Additional Information

Medicare Claims Processing Manual, Chapter 29 - Appeals of Claims Decisions, 310.2, 310.3 can be found on the CMS web site at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>

Medlearn Matters article MM3530 - “MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries” (CR Title - Appeals Transition - BIPA 521 Appeals) **Revised: 4/12/2005** can be found on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3530.pdf>

Change Request CR3530 “Revisions to Medicare Appeals Process for Fiscal Intermediaries” (CR Title - Appeals Transition – BIPA 521 Appeals) **Revised: 4/12/2005** can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R146OTN.pdf>

The official instruction issued to your FI, DMERC, or carrier regarding this change may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R697CP.pdf>

The new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR3942.

Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll free phone number, go on the CMS web site to:

<http://www.cms.hhs.gov/apps/contacts/>

## ***Clinical Laboratory Improvement Act (CLIA)***

### **New Waived Tests**

*Reference: Trans. 872, CR #4305, Pub. 100-04*

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. A complete list of CLIA Waived Tests can be found at:

[http://www.cms.hhs.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp#TopOfPage](http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp#TopOfPage)

However, the tests mentioned with CPT codes 81002, 81025, 82270, 82272, G0107, 82962, 83026, 84830, 85013 and 85651 do not require a QW modifier to be recognized as a waived test.

| <b>Waived Test Requiring QW Modifier</b>   | <b>CPT Code/Modifier</b> | <b>Effective Date</b> |
|--|--------------------------|-----------------------|
| Instant Technologies IScreen H.pylori Rapid Test Device  | 86318QW                  | September 27, 2005    |
| Polymer Technology Systems Cardiochek PA Analyzer (PTS Panels CHOL+HDL Test Panel Test Strips) | 82465QW<br>83718QW       | September 27, 2005    |
| Instant Technologies iScreen Mononucleosis Rapid Test Device (Whole Blood)                     | 86308QW                  | October 7, 2005       |
| Instant Technologies iScreen Mononucleosis Rapid Test Strip (Whole Blood)                      | 86308QW                  | October 7, 2005       |
| Fisher Scientific Sure-View RSV Test   | 87807QW                  | October 20, 2005      |
| SA Scientific SAS RSV Alert  | 87807QW                  | October 20, 2005      |
| SA Scientific SAS Influenza A Test   | 87804QW                  | November 23, 2005     |
| SA Scientific SAS Influenza B Test   | 87804QW                  | November 23, 2005     |

# Healthcare Common Procedure Coding System (HCPCS) Codes Subject to, and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

Reference: Trans. 865, CR #4321, Pub. 100-04, Medlearn Matters Number: MM4321

## *Provider Types Affected*

Providers and clinical laboratories that submit claims to Medicare carriers for CLIA-related services

## *Key Points*

The HCPCS codes that are considered laboratory tests under CLIA are subject to change each year. Effective January 1, 2006, there are new HCPCS codes, including modifiers, for 2006 that are either subject to CLIA edits or excluded from CLIA edits.

HCPCS codes subject to or excluded from CLIA edits are described in Change Request (CR) 4321 and in the attachments to that CR which revise the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Laboratory Services.

The new 2006 HCPCS codes are listed in Table 1, Appendix A, of this article. Please note that this list **does not** include new HCPCS codes for waived tests or provider-performed procedures.

These HCPCS codes are subject to CLIA edits, therefore a CLIA number must be submitted on claims by facilities for these HCPCS codes. The HCPCS codes listed in the Table 1 **require a facility to have** either:

- A CLIA certificate of registration (certificate type code 9);
- A CLIA certificate of compliance (certificate type code 1); **or**
- A CLIA certificate of accreditation (certificate type code 3).

Facilities will not be permitted to bill for the tests listed in Table 1, Appendix A, of this article:

- If they **do not have** a valid, current, CLIA certificate;
- If they **have** a current CLIA certificate of waiver (certificate type code 2); **or**
- If they **have** a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

Effective January 19, 1993, a laboratory that holds a certificate for provider-performed microscopy procedures may perform only those tests specified as provider-performed microscopy procedures and waived tests, and no others. The provider-performed microscopy procedures are described in Table 2, Appendix A of this article.

The following new HCPCS codes for 2006 in the 80000 series are excluded from CLIA edits and **do not require** a facility to have any CLIA certificate:

- 86923 - Compatibility test each unit; electronic;
- 86960 - Volume reduction of blood or blood products (e.g., red blood cells or platelets), each unit; and
- 87900 - Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics.

## *Relevant Links*

For a complete list of the specific HCPCS codes subject to CLIA edits please refer to the Centers for Medicare & Medicaid Services (CMS) web site at:

<http://www.cms.hhs.gov/CLIA/downloads/Subject.to.CLIA.pdf>

For a complete list of the specific HCPCS codes in the 80000 series that are excluded from CLIA edits please refer to the CMS web site at:

<http://www.cms.hhs.gov/CLIA/downloads/cpt4exc.pdf>

CR4321 is the official instruction issued to your carrier regarding changes mentioned in this article, MM4321. CR4321 may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R865CP.pdf>

Please refer to your local carrier if you have questions about this issue. To find the toll free phone number, go on the CMS web site to:

<http://www.cms.hhs.gov/apps/contacts/>

### Appendix A

The HCPCS codes listed in the chart below are new for 2006 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. Effective January 1, 2006, the HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3).

**Table 1: 2006 HCPCS Codes Subject to CLIA Edits**

| HCPCS | Modifier | Description  |
|-------|----------|--|
| 0103T |          | Holotranscobalamin, quantitative   |
| 0111T |          | Long-chain (C20 – 22) omega-3 fatty acids in red blood cell (RBC) membranes  |
| 80195 |          | Sirolimus  |
| 82271 |          | Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources   |
| 83631 |          | Lactoferrin, fecal; quantitative   |
| 83695 |          | Lipoprotein (a)  |
| 83700 |          | Lipoprotein, blood; electrophoretic separation and quantitation  |
| 83701 |          | Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)  |
| 83704 |          | Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (e.g., by nuclear magnetic resonance spectroscopy)  |
| 83900 |          | Molecular diagnostics; amplification of patient nucleic acid, multiplex, first two nucleic acid sequences  |
| 83907 |          | Molecular diagnostics; lysis of cells prior to nucleic acid extraction (e.g., stool specimens, paraffin embedded tissue)   |
| 83908 |          | Molecular diagnostics; signal amplification of patient nucleic acid, each nucleic acid sequence  |
| 83909 |          | Molecular diagnostics; separation and identification by high resolution technique (e.g., capillary electrophoresis)  |
| 83914 |          | Mutation identification by enzymatic ligation or primer extension, single segment, each segment (e.g., oligonucleotide ligation assay (OLA), single base chain extension (SBCE), or allele-specific primer extension (ASPE)) |
| 86200 |          | Cyclic citrullinated peptide (CCP), antibody   |
| 86355 |          | B cells, total count   |
| 86357 |          | Natural killer (NK) cells, total count   |
| 86367 |          | Stem cells (i.e., CD34), total count   |
| 86480 |          | Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response   |
| 87209 |          | Smear, primary source with interpretation; complex special stain (e.g., trichrome, iron hemotoxylin) for ova and parasites   |
| 88333 |          | Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site   |
| 88333 | TC       | Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site   |
| 88333 | 26       | Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site   |
| 88334 |          | Pathology consultation during surgery; cytologic examination (e.g., touch prep,  |

|       |    |   |
|-------|----|---|
|       |    | squash prep), each additional site  |
| 88334 | TC | Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site        |
| 88334 | 26 | Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site        |
| 88384 |    | Array-based evaluation of multiple molecular probes; 11 through 50 probes   |
| 88384 | TC | Array-based evaluation of multiple molecular probes; 11 through 50 probes   |
| 88384 | 26 | Array-based evaluation of multiple molecular probes; 11 through 50 probes   |
| 88385 |    | Array-based evaluation of multiple molecular probes; 51 through 250 probes  |
| 88385 | TC | Array-based evaluation of multiple molecular probes; 51 through 250 probes  |
| 88385 | 26 | Array-based evaluation of multiple molecular probes; 51 through 250 probes  |
| 88386 |    | Array-based evaluation of multiple molecular probes; 251 through 500 probes   |
| 88386 | TC | Array-based evaluation of multiple molecular probes; 251 through 500 probes   |
| 88386 | 26 | Array-based evaluation of multiple molecular probes; 251 through 500 probes   |
| 89049 |    | Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report |

Effective January 19, 1993, a laboratory that holds a certificate for provider-performed microscopy procedures may perform only waived tests and those tests specified as provider-performed microscopy procedures in the following table, and no others.

**Table 2: Provider-Performed Microscopy Procedures**

| HCPCS | Test   |
|-------|--|
| Q0111 | Wet mounts, including preparations of vaginal, cervical, or skin specimens   |
| Q0112 | All potassium hydroxide (KOH) preparations   |
| Q0113 | Pinworm examinations   |
| Q0114 | Fern test  |
| Q0115 | Post-coital direct, qualitative examinations of vaginal or cervical mucous   |
| 81015 | Urinalysis; microscopic only   |
| 81000 | Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy  |
| 81001 | Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy (NOTE: May only be used when the lab is using an automated dipstick urinalysis instrument approved as waived.) |
| 81020 | Urinalysis; two or three glass test  |
| 89055 | Fecal leukocyte examination  |
| 89190 | Nasal smears for eosinophils   |
| G0027 | Semen analysis; presence and/or motility of sperm excluding Huhner   |

## Coding & Coverage

### January 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2006, and Revisions to January 2005, April 2005, July 2005, and October 2005 Quarterly ASP Medicare Part B Drug Pricing Files

Reference: Trans. 856, CR #4140, Pub. 100-04, Medlearn Matters Number: MM4140

**Note:** This article was revised on February 17, 2006, to delete references to the revised January 2005 pricing file. CR4140 was revised by CMS to delete the same references since the revised January 2005 pricing file was not provided as indicated in the original CR4140. Also, the CR transmittal number, web address, and release date were also changed. Other web addresses were changed to conform to the new CMS web site. All other information remains the same.

#### ***Provider Types Affected***

All Medicare providers who bill Medicare for Part B drugs

#### ***Impact to You***

CR4140 provides notice of the updated payment allowance limits in the January 2006, April 2005, July 2005, and October 2005 drug pricing files.

#### ***What You Need to Know***

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

#### ***What You Need to Do***

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

#### ***Background***

According to section 303 (c) of the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the average sales price (ASP).

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files.

On or after December 19, 2005, revised April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005.
- The January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.

#### ***Exceptions***

There are, however, exceptions to the general rule and they were summarized in MM3846, effective July 1, 2005 and may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3783.pdf>

***Implementation***

The implementation date for this instruction is January 3, 2006.

***Additional Information***

The official instruction issued to your carrier/intermediary regarding this change may be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R856CP.pdf>

CMS will also update the Microsoft Excel files on the CMS web site to reflect these revised payment limits.

Those files can be found on the CMS web site at:

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

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

# Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Reference: Trans. 860, CR #4326, Pub. 100-04, Medlearn Matters Number: MM4326

## Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs)

## Key Points

- Effective December 29, 2005, **Remark Code MA02** was updated to reflect the following narrative:  
*“If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.”*
- Within 30 days of release of CR4326, **Remark Code MA03** will not be used for Medicare Fee for Service (FFS) and Medicare will update the current narrative of remark code MA02 in the same timeframe.
- Please use the text posted on the Washington Publishing Company (WPC) web site if there are discrepancies between any code text included in this article and the corresponding text on the WPC web site:  
<http://www.wpc-edi.com/codes>.

## Background

There are two code sets that must be used to report payment adjustments, appeal rights, and related information for transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice. These code sets, updated on a regular basis, include:

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

Additionally, for transaction 837 COB, CARC must be used.

## Additional Information

CR4326 is the official instruction issued to your FI/RHHI or your carrier/DMERC regarding changes mentioned in this article, MM4326. CR4326 may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R860CP.pdf>

Please refer to your local FI/RHHI or your carrier/DMERC if you have questions about this issue. To find their toll free phone number, go on the CMS web site to:

<http://www.cms.hhs.gov/apps/contacts/>

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

Reference: Trans. 859, CR #4314, Pub. 100-04, Medlearn Matters Number: MM4314

### Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services

### Impact to You

The complete list, including changes made from July 1, 2005, through October 30, 2005, of X12N 835 Remittance Advice Remark Codes and X12N 835 Claim Adjustment Reason Codes have been posted. The most current and complete code list will be found at <http://www.wpc-edi.com/codes>

### What You Need to Know

Please refer to the *Additional Information* section of this article for remark and reason code changes approved between July 1, 2005, to October 30, 2005, and in September, 2005, respectively. By April 3, 2006, all applicable code text changes and new codes should be in use and the deactivated codes terminated.

### What You Need to Do

The above codes are updated three times a year. Be sure your staff is aware of these changes in order to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

### Background

Two code sets—the claim adjustment reason code set and the remittance advice remark code set—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits transactions.

The remittance advice remark code (RARC) list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at <http://wpc-edi.com/codes>.

The RARC database has expanded rapidly in the last couple of years. CMS has developed a new Web site to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. You can also find at this site some other information that is available from the WPC Web site. The new web site address is: <http://www.cmsremarkcodes.info/>

**Note:** This web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

### Implementation

The implementation date for the instruction is April 3, 2006.

### Additional Information

The following list summarizes changes made from July 1, 2005, through October 30, 2005:

| Code   | New, Modified, Deactivated, Retired | Current Narrative  | Comment                |
|--|-------------------------------------|--|------------------------|
| <b>Remittance Advice Remark Code Changes</b> |                                     |  |                        |
| N357   | New                                 | Time frame requirements between this service procedure/supply and a related service procedure/supply have not been met.        | Medicare Initiated     |
| N358   | New                                 | This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. | Not Medicare Initiated |
| N359   | New                                 | Missing/incomplete/invalid height.   | Not Medicare Initiated |

|      |          |  |  |
|------|----------|--|--|
| N360 | New      | Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.  | Not Medicare Initiated                     |
| N361 | New      | Charges are adjusted based on multiple diagnostic imaging procedure rules.   | Not Medicare Initiated                     |
| N362 | New      | The number of Days or Units of Service exceeds our acceptable maximum.   | Not Medicare Initiated                     |
| N363 | New      | Alert: in the near future we are implementing new policies/procedures that would affect this determination.  | Not Medicare Initiated                     |
| N364 | New      | According to our agreement, you must waive the deductible and/or coinsurance amounts.  | Medicare Initiated                         |
| M16  | Modified | Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.  | Modified effective 11/18/05                |
| MA02 | Modified | If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.  | Modified effective 12/29/05 <sup>(1)</sup> |
| MA03 | Modified | If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.  | Modified effective 11/18/05 <sup>(2)</sup> |
| N9   | Modified | Adjustment represents the estimated amount a previous payer may pay.   | Modified effective 11/18/05                |
| N34  | Modified | Incorrect claim form/format for this service.  | Modified effective 11/18/05                |
| N207 | Modified | Missing/incomplete/invalid weight.   | Modified effective 11/18/05                |
| N355 | Modified | The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.<br>The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. | Modified effective 11/18/05                |

|   |             |   |  |
|---|-------------|---|--|
|   |             | However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days. |  |
| M78   | Deactivated | Missing/incomplete/invalid HCPCS modifier.  | Deactivated effective 5/18/06, consider using reason code 4. |
| <b>Claim Adjustment Reason Code Changes</b> |             |   |  |
| 190   | New         | Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.   | New as of 10/05  |
| 191   | New         | Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.   | New as of 10/05  |
| 192 <sup>(3)</sup>                          | New         | Non standard adjustment code from paper remittance advice.  | New as of 10/05  |
| 182   | Modified    | Payment adjusted because the procedure modifier was invalid on the date of service.   | Modified 8/8/05  |
| B18   | Modified    | Payment adjusted because this procedure code and modifier were invalid on the date of service.  | Modified 8/8/05  |
| 52  | Retired     | The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.   | Inactive as of 2/1/06  |
| B17   | Retired     | Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.  | Inactive as of 2/1/06  |

<sup>1</sup> This modification is effective January 1, 2006, and has been communicated in a separate instruction (CR 4326).

<sup>2</sup> Medicare will not use MA03 effective from January 1, 2006, and that has been communicated in CR4326.

<sup>3</sup> This new code was created at the request of Medicare because:

- Providers who do not qualify for Administrative Simplification Compliance Act (ASCA) exemption must submit claims electronically;
- If Medicare is secondary, and the primary payer has sent a paper RA with proprietary code(s), the provider could not send a compliant electronic claim unless a crosswalk between the payer proprietary codes and the standard CARC is available.

In CR4123, Medicare contractors were instructed to complete entry of 192 as a valid code, and accept claims containing this code for adjudication. CMS encourages providers to utilize this code, and submit COB claims electronically.

### Reason Codes 1 and 2

In September, CMS requested two new codes to be used in lieu of current reason codes 1 (“Deductible”) and 2 (“Coinsurance Amount”) when a provider is not allowed to collect any deductible and/or any coinsurance.

Section 630 of the Medicare Modernization Act (MMA) permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients.

The committee did not approve the CMS request for new codes, but suggested that reason codes 1 and 2 should be used with Group Code CO (Contractual Obligation) instead of PR (Patient Responsibility). Currently, in most

situations Group Code PR is used with reason codes 1 and 2. Medicare contractors must use Group code CO under this special situation with codes 1 and 2. See related CR3845 and the Medlearn Matters article on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3845.pdf>

The official instructions (CR4314) issued to your Medicare carrier, intermediary, DMERC, or RHHI regarding this change can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R859CP.pdf>

If you have questions, please contact your Medicare carrier/intermediary/DMERC/RHHI at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

# Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening

Reference: *Medlearn Matters* Number: SE0613

## **Provider Types Affected**

Physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, community surgical centers

## **Impact to You**

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible Medicare patients ages 50 and older to get screened for colorectal cancer. This *Medlearn Matters* Special Edition issue reviews Medicare coverage and billing processes for colorectal cancer screening.

## **What You Need to Know**

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

## **What You Need to Do**

Encourage your patients to be screened, appropriately bill Medicare for the screening test you provide, and follow up with patients, as needed.

## **Background**

Colorectal cancer is the second leading cause of cancer death in the United States and the third most common type of cancer. In 2005, colorectal cancer was expected to account for 56,290 deaths and 145,290 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. The data currently available (1998 - 2002) indicates that the colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends ("A" rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. To read the full recommendation, go to the following link:

<http://www.ahrq.gov/clinic/uspstf/uspscolo.htm>

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria - burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value.

## **Colorectal Cancer Screening Methods**

There are a variety of methods available for colorectal cancer screening, including fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and screening barium enema. It is important that practitioners follow the practice guidelines for screening and follow-up.

Two studies published in January 2005 in the *Annals of Internal Medicine* suggest that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up. Click on the following link for information on colorectal cancer detection and American Cancer Society screening recommendations and guidelines:

[http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_6X\\_Colorectal\\_Cancer\\_Early\\_Detection\\_10.asp?sitearea=&level](http://www.cancer.org/docroot/CRI/content/CRI_2_6X_Colorectal_Cancer_Early_Detection_10.asp?sitearea=&level)

## **Coverage**

Medicare covers the following colorectal cancer screening tests and procedures:

### **Fecal Occult Blood Test (FOBT)**

Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for one FOBT, not both, per year.

Beneficiaries do not have to pay coinsurance for the FOBT, and don't have to meet the annual Medicare Part B deductible.

### **Screening Flexible Sigmoidoscopy**

Medicare covers a screening flexible sigmoidoscopy once every four years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

### **Screening Colonoscopy**

Medicare coverage for a screening colonoscopy is based on beneficiary risk.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every 10 years, but not within 47 months of a previous screening flexible sigmoidoscopy.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age.

A screening colonoscopy must be ordered and provided by a doctor of medicine or osteopathy.

### **Screening Barium Enema**

Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy or a screening colonoscopy.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every four years.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every two years regardless of age.

A screening barium enema must be ordered in writing and provided by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying 20% of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema after meeting the annual Medicare Part B deductible.

For a screening flexible sigmoidoscopy or a screening colonoscopy performed in a hospital outpatient department, the beneficiary is liable for paying the Medicare-approved amount (the coinsurance) after meeting the annual Medicare Part B deductible.

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer;
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

### ***How to Bill Medicare***

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used to bill for colorectal cancer screening:

| HCPCS Code | HCPCS Code Descriptor   |
|------------|---|
| G0104      | Colon cancer screening; flexible sigmoidoscopy  |
| G0105*     | Colon cancer screening; colonoscopy on individual at high risk  |
| G0106      | Colon cancer screening; barium enema as an alternative to G0104   |
| G0107      | Colon cancer screening; FOBT, 1-3 simultaneous determinations   |
| G0120      | Colon cancer screening; barium enema as an alternative to G0105   |
| G0121      | Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk                                    |
| G0122**    | Colon cancer screening; barium enema (non-covered)  |
| G0328      | Colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations |

\* When billing for the “high risk” beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer screening chapter (page 81) of the Guide to Preventive Services. This guide is available on the CMS web site at: <http://www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf>

\*\* Code G0122 should be used when a screening barium enema is performed **not** as an alternative to either to G0104 or G0105. This service is denied as non-covered because it fails to meet the requirements of the benefit. **The beneficiary is liable for payment.** Reporting of this non-covered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

If billing Medicare carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing Medicare intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal cancer screening chapter (page 82) of the Guide to Preventive Services. This guide is available at: <http://www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf> on the CMS web site. Reimbursement information is also provided in this guide.

#### ***Other Helpful Information***

CMS has developed a comprehensive prevention web site that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes web site links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society:

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

Also, visit the Medicare Learning Network (MLN) website at <http://www.cms.hhs.gov/Medlearn/> to access the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* as well as other educational resources designed for health care professionals to promote and increase national awareness of Medicare-covered preventive services. Once on the MLN site, scroll to the bottom of the page and click on Products, then click on Preventive Services.

# April Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Reference: Trans. 880, CR #4335, Pub. 100-04, Medlearn Matters Number: MM4335

## ***Provider Types Affected***

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

## ***Provider Action Needed***

This article is based on Change Request (CR) 4335 and provides specific information regarding the quarterly update for the April 2006 DMEPOS Fee Schedule.

## ***Background***

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

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

Payment on a fee schedule basis is required for:

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

Changes made in this update include the following:

- The fee schedule amounts for HCPCS code **K0730**, *Controlled dose inhalation drug delivery system*, were added to the fee schedule file on April 1, 2006, and are effective for claims with dates of service on or after April 1, 2005.  
If processed claims for code K0730 with dates of service on or after April 1, 2005, are resubmitted as adjustments after April 1, 2006, carriers and DMERCs will adjust the claim.
- The fee schedule amounts for HCPCS code **E1010**, *Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest*, were inadvertently dropped from the January fee schedule file and are being added back to the file as part of the April 2006 update.
- The payment categories for codes **E0471** and **E0472** are being revised to move Respiratory Assist Devices from the DME category for frequently serviced items to the DME payment category for capped rental items, effective on April 1, 2006.

## ***Implementation***

The implementation date for this instruction is April 3, 2006.

## ***Additional Information***

The official instructions issued to your intermediary, carrier, or DMERC regarding this change can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R880CP.pdf>

If you have questions, please contact your Medicare intermediary, carrier, or DMERC at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

# Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

Reference: Trans. 816, CR #4085, Pub. 100-04, Medlearn Matters Number: MM4085

## Provider Types Affected

Physicians, suppliers, and providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for Ultrasound Stimulation for Nonunion Fracture Healing.

## Impact to You

This article is based on Change Request (CR) 4085, which supplements CR3836 - Coverage and Billing Requirements for Ultrasound Stimulation for Nonunion Fracture Healing.

## What You Need to Know

Effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery. Please note that there have been changes made to CR3836 business requirements. These changes are discussed in the *Additional Information* section of this article. All other material and information remain the same as in the original CR3836.

## What You Need to Do

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

## Background

The Centers for Medicare & Medicaid Services (CMS) determined that evidence is adequate to conclude that it is reasonable and necessary to use non-invasive ultrasound stimulation for the treatment of nonunion bone fractures prior to surgical intervention.

Therefore, effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery.

## Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

An ultrasonic osteogenic stimulator is a non-invasive device that emits low-intensity, pulsed ultrasound. This device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing.

Ultrasonic osteogenic stimulators are not to be used concurrently with other non-invasive osteogenic devices.

## Coverage Requirements

Effective for dates of service on and after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgical intervention. In demonstrating nonunion fractures, CMS expects a minimum of **two** sets of radiographs, obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days.

Each radiograph set must include multiple views of the fracture site, accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

For further coverage information, please refer to the Medicare *National Coverage Determinations Manual* (Pub.100-03), Chapter 1, Section 150.2, which can be found on the CMS web site at:

[http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part2.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf)

**Note:** Hospitals should note that there are no covered services for Ultrasonic Osteogenic Stimulation for which hospitals can be paid by the FI. Thus, hospitals can not bill for Ultrasonic Osteogenic Stimulators.

## Bill Types When Billing RHHIs

When billed to RHHIs, Ultrasonic Osteogenic Stimulators must be billed on type of bill 32X, 33X, 34X, and is payable under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

**Note:** Ultrasonic Osteogenic Stimulators must be in the patient's home health plan of care if billed on TOBs 32X or 33X.

### **Billing Instructions When Billing Medicare Carriers**

Effective for dates of service on or after April 27, 2005, carriers will allow payment for ultrasonic osteogenic stimulators with the following current procedural terminology (CPT) code:

- **20979** - Low intensity ultrasound stimulation to aid bone healing, noninvasive (non-operative).

### **Billing Instructions for Durable Medical Equipment Regional Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs)**

Effective for dates of service on or after April 27, 2005:

- DMERCs and RHHIs will allow payment for ultrasonic osteogenic stimulators with the following HCPCS codes:
  - Ø **E0760** for low-intensity ultrasound (include modifier “KF”); or
  - Ø **E1399** for other ultrasound stimulation (include modifier “KF”).
- RHHIs will:
  - Ø Pay for ultrasonic osteogenic stimulators only when services are submitted on type of bills (TOBs) 32X, 33X, or 34X;
  - Ø Pay HHAs on TOBs 32X, 33X, and 34X for ultrasonic osteogenic stimulators on the DMEPOS fee schedule.

**Note:** Medicare carriers, FIs, and RHHIs will adjust claims with dates of service on and after April 27, 2005, if brought to their attention.

### **Implementation**

The implementation date for the instruction is April 3, 2006.

### **Additional Information**

Some of the differences between CR3836 and the new CR4085 include the following:

- A modifier is not needed when billing code 20979 to a carrier as a result of CR4085.
- Modifier “KF” is now to be used when billing code E0760 or code E1399 to a DMERC or RHHI.

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R816CP.pdf>

If you have any questions, please contact your carrier/DMERC/FI/RHHI at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## Payment for Power Mobility Device (PMD) Claims

*Reference: Trans. 215, CR #4372, Pub. 100-20, Medlearn Matters Number: MM4372*

### ***Provider Types Affected***

Physicians, providers, and non-physician practitioners billing Medicare carriers, durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), and/or fiscal intermediaries (FIs) for PMDs and services related to prescribing PMDs

### ***Important Points to Remember***

#### **Options for Submitting G0372 and E/M Codes**

Providers billing a Medicare carrier have the following options for submitting the G0372 code and the E/M code during January 1, 2006, through March 31, 2006:

- Submit the G0372 code and E/M now on the same claim. Payment for these claims will be held through March 31, 2006.
- Hold all claims containing the G0372 code until after March 31, 2006.
- Submit the E/M service now and bill the G0372 code after March 31, 2006.

The E/M service will be paid now. Note that this is not intended to require that Medicare fiscal intermediaries or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician/provider may choose to submit two separate claims for the individual services.

Critical Access Hospitals billing the fiscal intermediary (FI) under Method II have the following options from January 1, 2006, through July 2, 2006, for submitting the G0372 code and the E/M code:

- Submit the G0372 and E/M now on the same claim. Payment for these claims will be held by the FI through July 2, 2006.
- Hold all claims containing the G0372 code until after July 2, 2006.
- Submit the E/M service now and bill the G0372 code after July 2, 2006. The E/M service will be paid now. Note that this is not intended to require the FIs or carriers to split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner may choose to submit two separate claims for the individual services.

Method II Critical Access Hospitals submitting claims on or after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

### ***Background***

The Centers for Medicare & Medicaid Services (CMS) published an interim final rule on PMDs to conform its regulations to section 302(a)(2)(E)(iv) of the Medicare Modernization Act (MMA), which is codified at section 1834(a)(1)(E)(iv) of the Social Security Act (SSA). The effective date of the rule was October 25, 2005.

For PMDs, the MMA mandated that:

- A face-to-face examination of the individual be conducted by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; and
- That payment may not be made for a motorized or power wheelchair unless the physician or treating practitioner has written a prescription for the item.

By defining the practitioners allowed to conduct the face-to-face examination, it also effectively removed the current requirement that a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology in order to get a power-operated vehicle (POV).

### **Submission of Medical Record and Prescription**

Apart from the MMA requirements, the other key change made by this regulation is a requirement that the physician or treating practitioner must submit pertinent parts of the medical record (in lieu of the Certificate of Medical Necessity (CMN)), along with the prescription, to the durable medical equipment (DME) supplier within 30 days of the face-to-face examination.

A separate add-on payment (an add-on payment to the office visit billed with the code of G0372) was established by the rule to recognize the additional physician work and resources required for submitting pertinent parts of the medical record.

Payment for the history and physical examination is made through the appropriate evaluation and management (E&M) code along with the add-on payment (G0372) which goes to the local Medicare fiscal intermediary or carrier. The PMD claim will go to the local durable medical equipment regional carrier (DMERC).

### **Appropriations Act**

Title II, Section 222, of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006 (H.R. 3010) (the Appropriations Act) was signed into law on December 30, 2005. It states, in part:

**SEC. 222.** None of the funds made available under this Act may be used to implement or enforce the interim final rule published in the Federal Register by the Centers for Medicare & Medicaid Services on August 26, 2005, (70 Fed. Reg. 50940) prior to April 1, 2006.

Although this section of the Appropriations Act does not allow federal funds to implement or enforce the rule, CMS believes that this section does not affect the validity of the rule. Therefore, CMS is instructing DMERCs and/or DME PSCs that, between January 1, 2006 to April 1, 2006, contractors will only pay PMD claims that satisfy the requirements of section 1834(a)(1)(E)(iv) of the SSA.

Based on the Appropriations Act, CMS is instructing fiscal intermediaries and carriers to hold claims that contain G0372. These claims must be held through March 31, 2006. Carriers will begin to release physician claims for processing on April 3, 2006.

### **Implementation**

The implementation date for this instruction is no later than two weeks after release of CR4372 or March 24, 2006.

### **Additional Information**

For additional information regarding PMDs you may want to review the following Medlearn Matters articles:

- MM4121: *MMA - New G Code for Power Mobility Devices (PMDs)*  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4121.pdf>
- MM3952: *MMA - Evidence of Medical Necessity: Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claims*  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3952.pdf>

The official instructions issued to your carrier, DMERC, FI, or RHHI regarding this change can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R215OTN.pdf>

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## *Comprehensive Error Rate Testing (CERT)*

*To view the CERT monthly newsletter, please visit your state website at:*

*Arkansas:* <http://www.arkmedicare.com/provider/cert/newsletters.asp>

*Louisiana:* <http://www.lamedicare.com/provider/cert/newsletters.asp>

*Missouri:* <http://www.momedicare.com/provider/cert/newsletters.asp>

*Oklahoma/New Mexico:* <http://www.oknmmedicare.com/provider/cert/newsletters.asp>

*Rhode Island:* <http://www.rimedicare.com/provider/cert/newsletters.asp>

## *Drug Pricing*

### **April 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File and Revisions to January 2005, April 2005, July 2005, October 2005, and January 2006 Quarter ASP Medicare Part B Drug Pricing Files**

*Reference: Trans. 876, CR #4319, Pub. 100-04, Medlearn Matters Number: MM4319*

#### ***Provider Types Affected***

All Medicare providers who bill Medicare for Part B drugs

#### ***Impact to You***

CR4319 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective April 1, 2006 through June 30, 2006, as well as revised payment files for the January 2005, April 2005, July 2005, October 2005, and January 2006 Quarter ASP Medicare Part B Drug Pricing Files.

#### ***What You Need to Know***

Be aware that certain Medicare Part B drug payment limits have been revised and that the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR4319.

#### ***What You Need to Do***

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

#### ***Background***

According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS, will be paid based on the ASP methodology. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS, will be paid based on 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

#### ***Exceptions to General Rule***

There are exceptions to this general rule as summarized below:

##### ***Blood and Blood Products***

For blood and blood products (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003.

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

### ***Infusion Drugs***

For infusion drugs furnished through a covered item of Durable Medical Equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted.

**The payment allowance limits were not updated in 2005.** For infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), the payment allowance limits are 95 percent of the first published AWP.

### ***Influenza, Pneumococcal, Hepatitis B Vaccines***

For influenza, pneumococcal, and hepatitis B vaccines, payment allowance limits are 95 percent of the AWP as reflected in the published compendia.

### ***Drugs Not Included in ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File***

For drugs (other than new drugs) not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, payment allowance limits are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing.

In determining the WAC-based payment limit, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) will follow the methodology specified in the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals) on the CMS web site at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf>

The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC.

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

### ***Radiopharmaceuticals***

The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Your carrier/FI will determine payment limits for radiopharmaceuticals based on the methodology in place as of November, 2003.

### ***New Drugs Produced or Distributed under a New Drug Application Approved by the Food and Drug Administration***

The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

### **How the ASP is Calculated**

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier payment allowance limits with the ASP files. On or after March 20, 2006, revised January 2005, April 2005, July 2005, October 2005, and January 2006 ASP and NOC payment files and the April 2006 ASP and NOC files will be available for download.

- The revised January 2005 payment allowance limits apply to dates of service January 1, 2005 through March 31, 2005.
- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005.
- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.

- The April 2006 payment allowance limits apply to dates of service April 1, 2006 through June 30, 2006.

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

For any drug or biological not listed in the ASP or NOC drug pricing files, your Medicare contractor will determine the payment allowance limits in accordance with the policies described in CR4319 and fiscal intermediaries will seek payment allowances from the local Medicare carrier.

***Implementation***

The implementation date for the instruction is April 3, 2006

***Additional Information***

The official instructions issued to your carrier/FI/RHHI/DMERC regarding this change can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R876CP.pdf>

If you have questions, please contact your Medicare carrier/FI/RHHI/DMERC at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

More information is available on the CMS web site at:

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

## *Electronic Data Interchange (EDI)*

### **2005 Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document**

*Reference: Trans. 871, CR #4260, Pub. 100-04, Medlearn Matters Number: MM4260*

#### ***Provider Types Affected***

Physicians and suppliers who submit electronic X12N 837 claim forms to Medicare carriers, including durable medical equipment regional carriers (DMERCs)

#### ***Background***

The Centers for Medicare & Medicaid Services (CMS) is updating the current inbound 837 Professional companion document to provide revisions, correct errors, and implement additional language to cover the new National Provider Identifier (NPI).

This companion document, which is attached to CR4260, supplements (but does not contradict) the X12N 837 Professional Implementation Guide and clarifies Medicare carrier and DMERC expectations regarding data/claim submission, processing, and adjudication. The revised companion guide will be available through your Medicare carrier and DMERC via their newsletter, web site, and and/or list serve postings.

#### ***Key Points***

The most important changes to the X12N 837 Professional Health Care Claim Companion Document clarify the specific processing or adjudication of the X12 837, and include the following:

#### **Additions**

- New NPI information statement – “*The National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX)*”;
- Revised taxonomy code set statement for an updated Washington Publishing Company URL, which is <http://www.wpc-edi.com/codes/taxonomy>;
- New “*Application Receiver Code*” title to GS03 statement;

#### **Corrections/Clarifications**

- Corrected qualifier statement to show that only valid qualifiers may be submitted and qualifiers submitted for Medicare processing that are not defined for use by Medicare could result in claim/transaction rejection;
- Correction of the SV104 anesthesia value statement - changing “units” to “minutes” and correcting the Implementation Guide page reference from “400” to “403”;
- Clarification of the SV104 and PS102 language to show that negative values submitted in these fields could result in claim rejection.

#### ***Additional Information***

Please note the following message, which will be included in the revised X12N 837 companion document:

“The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at <http://www.wpc-edi.com>. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional Implementation Guide.”

#### ***Relevant Links***

CR4260 is the official instruction issued to your carrier, including your DMERC, regarding this change. CR4260 may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R871CP.pdf>

Please contact your local carrier or DMERC if you have questions about this issue. To find the toll free phone number, go on the CMS web site to:

<http://www.cms.hhs.gov/apps/contacts/>

**837 v. 4010A1 Inbound Professional Claim  
Companion Document**

| Description               |  |  | Language | Page  |
|---------------------------|--|--|----------|---|
| <b>General Statements</b> |  |  |          |   |
|                           |  |  | R        | The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 may be rejected.   |
|                           |  |  | R        | Claims that contain percentage amounts with values in excess of 99.99 may be rejected.  |
|                           |  |  | R        | Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.  |
|                           |  |  | R        | Medicare Services will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.   |
|                           |  |  | R        | Only loops, segments, and data elements valid for the HIPAA Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.   |
|                           |  |  | O        | The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^,  , and :.<br>Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.   |
|                           |  |  | R        | You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the carrier translator. |
|                           |  |  | R        | When applicable, the National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108=XX).  |
|                           |  |  | R        | Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at <a href="http://www.wpc-edi.com/codes/taxonomy">http://www.wpc-edi.com/codes/taxonomy</a> . Claims submitted with invalid taxonomy codes will be rejected.                                      |
|                           |  |  | R        | All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange   |

|                                   |       |                            |     |   |     |
|-----------------------------------|-------|----------------------------|-----|---|-----|
|                                   |       |                            |     | (transmission).   |     |
|                                   |       |                            | O   | Medicare Services will reject an interchange (transmission) submitted with more than 9,999 loops.   |     |
|                                   |       |                            | O   | Medicare Services will reject an interchange (transmission) submitted with more than 9,999 segments per loop.   |     |
|                                   |       |                            | O   | Medicare Services will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.   |     |
|                                   |       |                            | R/O | Compression of files is not supported for transmissions between the submitter and Medicare Services.  |     |
|                                   |       |                            | R/O | Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted which are not defined for use in Medicare billing may cause the claim to be rejected. |     |
|                                   |       |                            | R/O | You may send up to four modifiers; however, the last modifier may not be considered. The Medicare Services processing system may only use the first three modifiers for adjudication and payment determination of claims.         |     |
|                                   |       |                            | O   | Medicare Services will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guides.   |     |
|                                   |       |                            | O   | Incoming 837 transactions that exceed 700 ISA-IEA's appended together per day will be rejected.   |     |
|                                   |       |                            | O   | The recommended file size for incoming 837 transactions should not be more than 13 megs. Incoming 837 transactions that exceed 13 megs may be rejected.   |     |
| <b>Interchange Control Header</b> |       |                            |     |   |     |
|                                   | ISA05 | Interchange ID Qualifier   | O   | Medicare Services will reject an interchange (transmission) that does not contain ZZ in ISA05.  | B.4 |
|                                   | ISA06 | Interchange Sender ID      | O   | Medicare Services will reject an interchange (transmission) that does not contain a valid ID in ISA06.  | B.4 |
|                                   | ISA07 | Interchange ID Qualifier   | O   | Medicare Services will reject an interchange (transmission) that does not contain qualifier ZZ in ISA07.  | B.4 |
|                                   | ISA08 | Interchange Receiver ID    | O   | Medicare Services will reject an interchange (transmission) that does not contain 00520 for AR, 00528 for LA, 00523 for MO, 00521 for NM, 00522 for OK or 00524 for RI in ISA08. Each individual Contractor determines this code. | B.5 |
|                                   | ISA13 | Interchange Control Number | O   | It is recommended that the Interchange Control Number (ISA13) be a unique number in each interchange (transmission).  | B.5 |
| <b>Functional Group Header</b>    |       |                            |     |   |     |
|                                   |       |                            | O   | Medicare Services will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA  |     |

|             |                          |                                  |   |   |     |
|-------------|--------------------------|----------------------------------|---|---|-----|
|             |                          |                                  |   | (Interchange).  |     |
|             |                          |                                  | O | Medicare Services will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).   |     |
|             | GS03                     | Application Receiver's Code      | O | Medicare Services will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.   | B.8 |
| <b>Loop</b> | <b>Transaction Set</b>   |                                  |   |   |     |
|             |                          |                                  | O | Medicare Services will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected. |     |
|             | ST02                     | Transaction Control Set          | O | Medicare Services will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.   | 62  |
|             | BHT02                    | Transaction Set Purpose Code     | O | Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).  | 64  |
|             | BHT06                    | Claim/Encounter Identifier       | O | Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).  | 65  |
|             | REF02                    | Transmission Type Identification | O | The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 may cause the file to be rejected.                                | 66  |
| 1000A       | NM109                    | Submitter ID                     | R | Medicare Services will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.                                      | 69  |
| 1000B       | NM103                    | Receiver Name                    | O | Medicare Services will reject an interchange (transmission) that is not submitted with a valid carrier name (NM1).  | 75  |
| 1000B       | NM109                    | Receiver Primary Identifier      | O | Medicare Services will reject an interchange (transmission) that is not submitted with a valid carrier code (NM1). Each individual Contractor determines this code.   | 75  |
| 2000B       | HL                       | Subscriber Hierarchical Level    | O | The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.  | 108 |
| 2000B       | SBR02, SBR09             | Subscriber Information           | R | For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.   | 111 |
| 2010BD      |                          | Credit/Debit Card Information    | R | Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).  | 150 |
| <b>Loop</b> | <b>Claim Information</b> |                                  |   |   |     |
| 2300        | CLM02                    | Total Submitted Charges          | R | Negative values submitted in CLM02 may not be processed and may result in the claim being rejected.   | 172 |
| 2300        | CLM02                    | Total Submitted Charges          | R | Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).   | 172 |
| 2300        | CLM05-3                  | Claim Frequency Type Code        | R | The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1"  | 173 |

|      |              |   |     |   |             |
|------|--------------|---|-----|---|-------------|
|      |              |   |     | may be rejected.  |             |
| 2300 | CLM20        | Delay Reason Code                       | R   | Data submitted in CLM20 will not be used for processing.  | 179         |
| 2300 | PWK          | Claim Supplemental Information          | O   | Any data submitted in the PWK (Paperwork) segment may not be considered for processing.   | 214         |
| 2300 | AMT01        | Credit/Debit Card Maximum Amount        | R   | Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).  | 219         |
| 2300 | AMT02        | Patient Amount Paid                     | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.   | 220         |
| 2300 | AMT02        | Total Purchased Service Amount          | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.   | 221         |
| 2300 | REF02        | Prior Authorization and Referral Number | O   | Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) will be ignored.                 | 227         |
| 2300 | CR102, CR106 | Ambulance Transport Information         | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: CR102, CR106.  | 249, 250    |
| 2300 | HI           | Health Care Diagnosis Code              | R   | Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.  | 265         |
| 2300 | HI           | Health Care Diagnosis Code              | R   | Effective October 2004, all diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes, pointed to or not, will be rejected. | 265         |
| 2300 | HI           | Health Care Diagnosis Code              | R/O | You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes may not be considered in processing.   | 265         |
| 2320 | AMT02        | Coordination of Benefits Amounts        | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.   | 332<br>333  |
| 2400 | SV102        | Line Item Charge Amount                 | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: SV102.   | 402         |
| 2400 | SV104        | Professional Service                    | R   | Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. (SV104)  | 403         |
| 2400 | SV104        | Professional Service                    | O   | The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)                                    | 403         |
| 2400 | SV104        | Professional Service                    | O   | The max value for units (qualifier UN) cannot exceed three bytes numeric with one decimal place. Claims for medical services that exceed this value will be rejected. (SV104)                         | 403         |
| 2400 | SV104        | Professional Service                    | R   | SV104 (Service unit counts) (units or minutes) cannot exceed 999.9.   | 403         |
| 2400 | SV104        | Professional Service                    | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: SV104.   | 403         |
| 2400 | CR102, CR106 | Ambulance Transport                     | R   | Negative values submitted in the following fields may not be processed and may result in the claim  | 413,<br>414 |

|   |       |                      |     |  |      |
|---|-------|----------------------|-----|--|------|
|   |       | Information          |     | being rejected: CR102, CR106.  |      |
| 2400                                    | PS1   | Purchased Service    | O   | Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims for PDT services that are submitted without the PS1 segment data at the 2400 loop may be rejected. | 489  |
| 2400                                    | PS102 | Purchased Service    | R   | Negative values submitted in the following fields may not be processed and may result in the claim being rejected: PS102   | 490  |
| 2410                                    | CTP04 | Professional Service | O   | The max value for international units (qualifier F2), in the CTP segment, cannot exceed seven bytes numeric with three decimal places. Claims for drugs that exceed this value will be rejected.                                 | 403  |
| <b>997 – Functional Acknowledgement</b> |       |                      |     |  |      |
|   |       |                      | R/O | We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.   | B.15 |
|   |       |                      | R/O | Medicare Services will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.  |      |

## Standard Paper Remittance Mail Out to Discontinue

*Reference: AR – LHT 032206*

Are you still using the Standard Paper Remittance (SPR)? The time has come to **STOP** the paper remittance mail out. Take advantage of the FREE Medicare Remit Easy Print (MREP) software now available for viewing and printing the HIPAA compliant Electronic Remittance Advice (ERA)!

Effective June 1, 2006, all providers enrolling in ERA for the first time will continue to get paper remits for 30 days after setup date. At that time, the paper remit mail out will be discontinued.

Effective June 1, 2006, all current ERA providers will have their paper remit mail out discontinued.

In the near future, you will receive a call from your EDI representative to assist you in getting on board with MREP. The software gives providers and suppliers the following abilities:

- Easy navigation and viewing of the ERA using your personal computer;
- Print the ERA in the Standard Paper Remittance format;
- Search capability that allows providers and suppliers the ability to find claims information easily;
- Print and export reports about ERAs including denied, adjusted and deductible applied claims;
- Easy-to-use method to archive, restore, and delete imported ERAs

Providers and suppliers can view and print as many or as few claims as needed. This will be especially helpful when you need to print only one claim from the remittance advice when forwarding the claim to a secondary payer. This FREE software can save you time resolving Medicare claim issues. Take advantage of the MREP features that are unavailable with the current SPR.

In order to utilize the MREP software, you will need to receive a HIPAA compliant ERA. Contact EDI Services toll free at (866) 582-3247 or (501) 378-2419 to find out more about MREP and/or for information on how to receive a HIPAA compliant ERA. Take advantage of this new software now. Begin using MREP today!"

## *End Stage Renal Disease (ESRD)*

### **Repeat Tests for Automated Multi-Channel Chemistries for End Stage Renal Disease (ESRD) Beneficiaries**

*Reference: Trans. 733, CR #4101, Pub. 100-04, Medlearn Matters Number: MM4101*

#### ***Provider Types Affected***

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services provided to Medicare ESRD beneficiaries

#### ***Impact to You***

This article is based on Change Request (CR) 4101 provides details regarding the payment policy for End Stage Renal Disease (ESRD) - related Automated Multi-Channel Chemistry (AMCC) Tests (i.e., the ESRD 50/50 rule), and clarifies a coding issue concerning repeat tests using the Current Procedure Terminology (CPT) modifier 91.

#### ***What You Need to Know***

Clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **Modifier 91 must be used on any subsequent service** being billed if 1) any single service (same CPT code) is ordered (for the same beneficiary), and 2) the specimen is collected more than once in a single day, and the service is medically necessary. Also, any line item on a claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

#### ***What You Need to Do***

Please see the *Background* section of this article for further details.

#### ***Background***

##### **ESRD 50/50 Rule**

The Centers for Medicare & Medicaid Services (CMS) previously issued instructions to Medicare carriers regarding procedures to enforce compliance with the payment policy for End Stage Renal Disease (ESRD)-related Automated Multi-Channel Chemistry (AMCC) Tests (i.e., the ESRD 50/50 rule). The ESRD 50/50 rule requires a count of AMCC tests ordered to capture:

- The number of tests included in the composite payment rate paid to the ESRD facility; or
- The monthly capitation payment made to the furnishing physician;

##### ***Versus***

- The number of covered non-composite tests performed for the same beneficiary, on the same date of service.

The proportion of the composite payment rate tests **versus** the number of covered non-composite tests calculated by the billing laboratory is used to determine whether separate payment may be made for all tests performed on that day.

In CR2813, CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of CR2813 in the January 2005 release.

**Note:** The carrier standard system changes needed to implement the new ESRD 50/50 rule compliance guidelines were partially implemented in the October 2004 release. Intermediary billing guidelines for ESRD 50/50 rule compliance have been in effect since October 2003.

CR2813 also directed the carriers not to post any information concerning the business requirements associated with the implementation of CR2813 until receiving further guidance from CMS.

#### **Business Requirements Relating to Modifier 91**

In June 2005, CMS issued CR3890, which required the implementation of the ESRD 50/50 rule for Carriers, effective January 2006. During the preparation for implementation, the provider community commented that business requirements relating to the use of Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) were **inconsistent** with Current Procedural Terminology (CPT) procedures. CMS is adjusting the business requirements for proper use of Modifier 91.

A Medlearn Matters article, MM3890, is available for CR3890 on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3890.pdf>

Therefore, CR4101 directs that clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **Modifier 91 must be used on any subsequent service** being billed if:

- Any single service (same CPT code) is ordered (for the same beneficiary); and
- The specimen is collected more than once in a single day; and
- The service is medically necessary.

In addition, when using CPT Modifier 91, it must be used without regard to whether it is a:

- Composite rate test (Healthcare Common Procedure Coding System (HCPCS) Modifier CD);
- Composite rate test beyond the normal frequency (HCPCS Modifier CE); or
- Non-composite rate test (HCPCS Modifier CF).

**Note:** Any claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

### ***Implementation***

The implementation date for the instruction is April 3, 2006.

### ***Additional Information***

For complete details regarding CR4101, please see the official instruction issued to your carrier or intermediary regarding this change. That instruction may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R733CP.pdf>

From that web page, look for CR4101 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier or intermediary at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## General

### Epley Maneuver Update

Reference: LA – DJL 030106

*The following article is an update to the Epley Maneuver article published in the August 2005 Medicare Providers' News.*

Diagnosis code 780.4, dizziness and giddiness, light-headedness, and vertigo NOS, has been added as an allowable diagnosis for the performance of the Epley Manuever procedure.

As stated in the August 2005 *Medicare Providers' News*, providers are to bill miscellaneous code, 92700, if only the epley maneuver is done for a single Date of Service (DOS). When performed during an E&M service, the epley maneuver is bundled in the E & M service. It is reviewed by a clinician and paid only for the following diagnosis 386.11, benign paroxysmal positional vertigo, 780.4, dizziness and giddiness, light-headedness, and vertigo NOS.

John Eply, (1973) developed the Canalith Theory as the cause for 386.11 and developed the Canalith Repositioning Maneuvers for treatment of benign paroxysmal positional vertigo.

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### Clinical Trial Reminder

Reference: LA – MKS 030806

CMS has issued a National Coverage Determination (NCD) which allows Medicare coverage for the routine costs of qualifying clinical trial services as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in **all** clinical trials. The coverage requirements for routine costs of qualifying clinical trial services are contained in section 310.1 of the National Coverage Determinations Manual.

There is basic information that CMS requires be included on claims filed for clinical trials. These items are:

1. A secondary diagnosis of V70.7—examination of participant in clinical trial;
2. The GV modifier.

In addition the Carrier Medical Directors ask that you also submit the clinical trial number on all claims.

The claim cannot be processed correctly if one of the above items is missing on the claim.

## Laboratory Services

### Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2006

Reference: Trans. 864, CR #4328, Pub. 100-04, Medlearn Matters Number: MM4328

#### Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for clinical diagnostic laboratory services

#### Impact to You

This article is based on Change Request (CR) 4328, which announces the implementation of changes to the list of codes associated with the 23 negotiated laboratory NCDs, and the update of the laboratory edit module for changes in the laboratory NCD code lists for April 2006.

#### What You Need to Know

The changes to the list of codes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. Several of the listed changes correct codes to reflect the recent Current Procedural Terminology (CPT) update and are necessary so that the laboratory edit module will appropriately process claims using the most current negotiated laboratory NCDs and code lists.

#### What You Need to Do

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

#### Background

In accordance with the Balanced Budget Act of 1997 (Section 4554), the Centers for Medicare & Medicaid Services (CMS) entered into negotiated rulemaking proceedings to develop national coverage determinations (NCDs) for clinical diagnostic laboratory services. Under the negotiations, CMS developed 23 laboratory NCDs, and these NCDs are different than most other Medicare NCDs in that they include lists of ICD-9-CM codes. All codes are included on one of the following lists:

- Covered codes;
- Not covered codes; and
- Codes that do not support medical necessity.

The NCDs were published under the Administrative Procedures Act in the Federal Register of November 23, 2001 ([http://www.access.gpo.gov/su\\_docs/fedreg/a011123c.html](http://www.access.gpo.gov/su_docs/fedreg/a011123c.html)), and the list of 23 laboratory NCDs is included in the *Additional Information* section of this article. In addition, the CMS website for Laboratory NCDs can be found at [http://www.cms.hhs.gov/CoverageGenInfo/05\\_LabNCDs.asp](http://www.cms.hhs.gov/CoverageGenInfo/05_LabNCDs.asp) on the CMS web site.

Nationally uniform software was developed by Computer Sciences Corporation (CSC) and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. The laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

(See the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 16, Section 120.2, on the CMS web site at:

<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

CMS updates the NCD code list quarterly as necessary to incorporate new codes, correct ministerial errors, incorporate the results of Coding Analysis published elsewhere on this site, and incorporate reconsideration of the NCDs that alter covered indications. The quarterly updates are published in the NCD Coding Policy Manual, and you can download the current and previous coding manuals from this site. Alternatively, you can access individual NCDs from the lab index included on the following CMS website:

[http://www.cms.hhs.gov/mcd/index\\_section.asp?ncd\\_sections=40](http://www.cms.hhs.gov/mcd/index_section.asp?ncd_sections=40)

Change Request (CR) 4238 announces the changes that will be included in the April 2006 release of the edit module for clinical diagnostic laboratory services. The changes are a result of coding analysis decisions developed

under the procedures for maintenance of codes in the negotiated NCDs. Several of the listed changes correct codes to reflect the current CPT update. CR4238 communicates requirements to the laboratory edit module to update it for the following changes in laboratory NCD code lists for April 2006:

**Blood Count NCD**

Add the following ICD-9-CM code to the list of **codes that do not support medical necessity** for the Blood Count NCD:

| Add ICD-9-CM Code | Descriptor                                       |
|-------------------|--|
| V76.51            | Special screening for malignant neoplasms, colon |

**ICD-9-CM Codes Never Covered by Medicare**

Delete the following ICD-9-CM code from the list of ICD-9-CM **codes never covered** by Medicare:

| Deleted ICD-9-CM Code | Descriptor                                       |
|-----------------------|--|
| V76.51                | Special screening for malignant neoplasms, colon |

**Fecal Occult Blood Test NCD**

Add the following new CPT code to the list of HCPCS/CPT codes covered by Medicare for Fecal Occult Blood Test NCD:

| Add CPT Codes | Descriptor              |
|---------------|-------------------------|
| 82272         | Blood occult peroxidase |

Delete the following CPT code from the HCPCS/CPT code list for Fecal Occult Blood Test NCD:

| Delete CPT Codes | Descriptor         |
|------------------|--------------------|
| 82270            | Fecal occult blood |

**Hepatitis Panel/Acute Hepatitis Panel NCD**

Add the following ICD-9-CM code to the list of ICD-9-CM codes covered by Medicare for Hepatitis Panel/Acute Hepatitis Panel NCD:

| Add ICD-9-CM Code | Descriptor   |
|-------------------|--|
| 790.4             | Nonspecific Elevation of Levels of Transaminase or Lactic Acid Dehydrogenase |

**Lipids Testing NCD**

Add the following new CPT codes to the list of HCPCS/CPT codes covered by Medicare for Lipids Testing NCD:

| Add CPT Codes | Descriptor                       |
|---------------|----------------------------------|
| 83700         | Lipoprotein bld, electrophoretic |
| 83701         | Lipoprotein bld, hr fraction     |

Delete the following CPT codes from the HCPCS/CPT code list for Lipids Testing NCD:

| Delete CPT Codes | Descriptor  |
|------------------|---|
| 83715            | Lipoprotein, blood: electrophoretic separation and quantitation           |
| 83716            | High resolution fractionation and quantitation of lipoprotein cholesterol |

## Urine Culture, Bacterial NCD

Delete Coding Guideline 1 in the Urine Culture, Bacterial NCD, and renumber the remaining Coding Guidelines.

**Note:** Changes included in the April 2006 release of the edit module for clinical diagnostic laboratory services become effective for services furnished on or after April 1, 2006.

### Implementation

The implementation date for the instruction is April 3, 2006.

### Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R864CP.pdf>

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

The following table includes the list of all twenty-three (23) Laboratory National Coverage Determinations, and each NCD can be reviewed on the CMS website at:

[http://www.cms.hhs.gov/mcd/index\\_section.asp?ncd\\_sections=40](http://www.cms.hhs.gov/mcd/index_section.asp?ncd_sections=40)

| Laboratory National Coverage Determination (NCD) |  |
|--|--|
| 1.   | Alpha-fetoprotein (AFP) (190.25)   |
| 2.   | Blood Counts (190.15)  |
| 3.   | Blood Glucose Testing (190.20)   |
| 4.   | Carcinoembryonic Antigen (CEA) (190.26)  |
| 5.   | Collagen Crosslinks, any Method (190.19)   |
| 6.   | Digoxin Therapeutic Drug Assay (190.24)  |
| 7.   | Fecal Occult Blood Test (FOBT) (190.34)  |
| 8.   | Gamma Glutamyl Transferase (GGT) (190.32)  |
| 9.   | Glycated Hemoglobin/Glycated Protein (190.21)  |
| 10.  | Hepatitis Panel/Acute Hepatitis Panel (190.33)                                       |
| 11.  | Human Chorionic Gonadotropin (hCG) (190.27)  |
| 12.  | Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14)                      |
| 13.  | Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring) (190.13) |
| 14.  | Lipid Testing (190.23)   |
| 15.  | Partial Thromboplastin Time (PTT) (190.16)   |
| 16.  | Prostate Specific Antigen (PSA) (190.31)   |
| 17.  | Prothrombin Time (PT) (190.17)   |
| 18.  | Serum Iron Studies (190.18)  |
| 19.  | Thyroid Testing (190.22)   |
| 20.  | Tumor Antigen by Immunoassay - CA 125 (190.28)                                       |
| 21.  | Tumor Antigen by Immunoassay - CA 15-3/CA 27.29 (190.29)                             |
| 22.  | Tumor Antigen by Immunoassay - CA 19-9 (190.30)                                      |
| 23.  | Urine Culture, Bacterial (190.12)  |

## *National Provider Identifier (NPI)*

### **Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms**

*Reference: Trans. 204, CR #4320, Pub. 100-20, Medlearn Matters Number: MM4320*

#### ***Provider Types Affected***

Physicians, providers, and suppliers who submit claims to Medicare carriers, including durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)

#### ***Provider Action Needed***

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

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

CMS has endorsed the Workgroup for Electronic Data Interchange (WEDI) Dual NPI-Legacy Identifier strategy for cross-health care industry implementation of the NPI.

The *Dual Use of NPI & Legacy Identifiers* paper is available at: <http://www.wedi.org/snip/public/articles/>. (Once at the site, scroll down and look for the paper issued on 01/22/2006.)

The remainder of this article describes CMS' current plans for a staged process leading to full implementation of the adoption of the NPI in Medicare transactions involving providers.

#### ***Background***

Implementation involves acceptance and processing of transactions that use the NPI in lieu of the previously used OSCAR, UPIN, PIN, and National Supplier Clearinghouse (NSC) numbers. The WEDI strategy provides for four stages during which system change schedules of trading partners will occur independently of each other.

**Medicare fee-for-service (FFS) transaction implementation for NPI** will occur in the following stages:

#### **Stage 1 (January 1, 2006 – October 1, 2006)**

During this stage, the NPI will be accepted on inbound claims, other than NCPDP claims, and other transactions but will not be used for Medicare processing. CR4320 focuses primarily on Stage 1 of the NPI implementation process. During stage 1:

- The “Legacy Identifier” (pre-NPI provider identifiers) will be used to identify providers while Medicare carriers, DMERCs, and intermediaries make sure that X12 837 version 4010A1 claims and other X12 HIPAA adopted transactions are not rejected due to the presence of an NPI.  
(Transactions may be submitted with or without an NPI during stage 1, as long as the Medicare legacy identifier is still reported.)
- Additionally, NPIs will be edited to verify that they meet basic structure requirements established for NPIs.
- Medicare will allow NPIs on the X12 270 version 4010A1 eligibility inquiry and the 276 claim status inquiry and return them in the respective X12 271 or 277 response, as long as the legacy identifier is also reported in the 270 or the 276.
- NPIs, as well as legacy identifiers, will be reported in coordination of benefit claims sent to trading partners when submitted on claims submitted to Medicare.
- NPIs will NOT be reported in the following outbound transactions during Stage 1, even if an NPI was submitted on related claims:
  - Ø X12 835 claims; or
  - Ø SPRs (standard paper remittance) formats

- Medicare carriers, DMERCs, and intermediaries must **reject the following transactions if submitted with NPIs**, since it is not possible to report both NPIs and legacy identifiers for providers in these transactions:

- Ø **NCPDP claims;**

- Ø **DDE claims, claim status and eligibility inquiries;**

- Ø **UB-92 (CMS-1450) paper claims** (the National Uniform Billing Committee [NUBC] announced that the use of the UB-04, which is able to report the NPI and a legacy identifier for each provider involved with a claim, will begin March 1, 2007, and that May 22, 2007, is the last day that a payer should accept a UB-92 form). Since it is not possible to report both a legacy identifier and an NPI on the UB-92, submitters of the UB-92 will be limited to reporting of their legacy identifier on those claims; and

- Ø **CMS-1500 paper claims** until the National Uniform Claim Committee implements a revised 1500 and CMS announces its implementation of that revised form.

The NUCC has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006, and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007, and later, payers should accept only the revised CMS-1500 form. Both the NPI and the legacy identifier can be reported on the revised CMS-1500 form, but not on the form currently in use. Until a provider begins to use the revised form, that provider will be limited to submission of legacy identifiers on the non-revised CMS-1500 form.

### **Stage 2: (October 2, 2006 – May 22, 2007)**

During this stage:

- Providers, clearinghouses, and billing services will be directed to provide a Medicare legacy identifier as a secondary identifier when NPIs are submitted as the primary provider identifiers in their X12 837 claims.
- The Legacy Identifier alone can still be used to identify those providers that have not yet obtained an NPI.
- The transitional Dual NPI-Legacy Identifier strategy includes the development of a crosswalk between Medicare legacy numbers and their associated NPIs. The crosswalk should help Medicare validate most NPIs to ascertain that they were actually issued to the providers for which reported, and will help to identify transcription errors in a reported NPI. The Crosswalk will begin operating at the onset of stage 2.
- If you use free billing software supplied by your carrier, DMERC, or intermediary/RHHI, it will be modified for stage 2 to permit reporting of your NPI, once received, and your legacy Medicare provider identifier. You will need to download the new version of the software when notified it is available.

The 835 PC-Print and Easy Print software for printing of remittances will also be updated for stage 2 to permit reporting of NPIs as well as legacy numbers when both are reported in an 835 transaction. Be sure to download the new version of that software when notified it is available.

- DDE screens will be modified for this stage to accept and return both NPIs, when available, and legacy identifiers.
- NPIs, when available in Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs during stage 2.

### **Stage 3 (May 23, 2007 – and Later)**

Stage 3 involves the transition to full use of the NPI for acceptance and processing of transactions, **except** for coordination of benefits (COB) claims that Medicare sends to small trading partners.

- HIPAA prohibits the reporting of any provider legacy identifiers to other than small health plans during this period (e.g., plans with less than \$5 million in annual receipts).
- All claims, including NCPDP claims, and 270, 276, and 277 attachment transactions sent to Medicare, must contain the NPI in lieu of the legacy identifier (please see Stage 4 below regarding claims). Those that do not are to be rejected.
- Legacy identifiers will no longer be sent to coordination of benefits (COB) trading partners or on outbound electronic or paper Medicare transactions or correspondence.

#### **Stage 4 (May 23, 2007 – May 22, 2008)**

Stage 4 involves completion of transition to the full use of NPI by all small trading partners. NPIs, rather than legacy identifiers, will be reported in all 837 version 4010A COB and NCPDP claims sent to small trading partners.

#### ***Additional Information***

CR4320 is the official instruction issued to your FI, including RHHI, or carrier, including DMERC, regarding changes mentioned in this article. CR4320 can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>

You may also want to review *Medlearn Matters* Special Edition SE0555, concerning the NPI. That article is available on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf>

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

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## **Announcement of Redesigned National Provider Identifier (NPI) Web Page**

*Reference: JSM CI 3667-06184, 01-23-06*

Announcing the **redesigned** CMS web page dedicated to providing all the latest NPI news for health care providers! Visit <http://www.cms.hhs.gov/NationalProvIdentStand/> on the web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml> on the web.

To apply for an NPI, visit: <https://nppes.cms.hhs.gov> on the CMS website

## NPI – Medicare Policy on Subpart Designation

Reference: Medlearn Matters Number: SE0608

### Provider Types Affected

Provider types affected include organization health care providers and suppliers who are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and who are enrolled in the Medicare program. These are certified providers and suppliers, supplier groups and supplier organizations, and suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

(This information does not apply to health care providers who are enrolled in Medicare as individual practitioners, such as physicians and nurse practitioners, nor does it apply to sole proprietors.)

### Key Points

- Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions to the new National Provider Identifier, or NPI.
- For Medicare organization health care providers, the current identifiers could include:
  - Ø Online Survey Certification and Reporting (OSCAR) system numbers;
  - Ø National Supplier Clearinghouse (NSC) numbers;
  - Ø Provider Identification Numbers (PINs); and
  - Ø Unique Physician Identification Numbers (UPINs) used by Medicare.

These numbers are now considered **legacy identifiers or legacy numbers**. Medicare is transitioning from these legacy identifiers to **National Provider Identifiers, or NPIs**.

**Note:** When applying for an NPI, Medicare providers are urged to include their legacy numbers, particularly their Medicare legacy number, on the NPI application form.

- By regulation, Medicare organization health care providers who are HIPAA covered entities must obtain NPIs. The NPIs will replace the identifiers currently in use in standard transactions with Medicare and with other health plans. Additionally, these **health care providers must determine if they have subparts that need to be uniquely identified** in standard transactions with their own NPIs.

### Background

**Organization health care providers** are corporations, partnerships, or other types of businesses that are considered separate from an individual by the state in which they exist. Subparts of such organization health care providers are also Organizations. All of these health care providers would apply for NPIs as Organizations (Entity Type 2).

**Note:** In terms of NPI assignment, an Individual is an Entity Type 1 (Individual), and is eligible for a single NPI. As an Individual, a physician or nurse practitioner, for example, as well as a sole proprietor/sole proprietorship, cannot have subparts and cannot designate subparts.

Most Medicare organization health care providers (Entity Type 2 providers) send electronic claims to Medicare (standard transactions), making them covered health care providers (HIPAA covered entities).

### Subpart Designation Guidelines

Covered organization health care providers are responsible for determining if they have “subparts” that need to have NPIs. If they do, the covered organization health care providers must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

Below are some guidelines to help determine if an enrolled Medicare organization health care provider has a subpart which will need its own unique NPI.

Regarding all of the entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization healthcare provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR 160.103. (This information can be found at <http://www.hhs.gov/ocr/regtext.html> on the Department of Health and Human Services (DHHS) web site.)

Regarding some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. If such statutes or regulations exist, the health care providers to whom they apply would need NPIs in order to ensure they can continue to be uniquely identified.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

### **Medicare Organization Subpart Examples**

#### ***Enrolled Certified Providers and Suppliers***

An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN (Tax Identification Number) of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, Medicare encourages that the hospital mirror its Medicare enrollment and obtain a total of 11 unique NPIs in order to help avoid claims processing delays (one NPI for the hospital, and one for each of the 10 home health agencies).

#### ***Enrolled Supplier Group or Supplier Organization***

An enrolled Independent Diagnostic Testing Facility (IDTF) has four different locations, and each one must be separately inspected by the carrier. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, Medicare encourages the IDTF to mirror its Medicare enrollment and obtain a total of four unique NPIs in order to help avoid claims processing delays (one NPI for each location).

#### ***Enrolled Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)***

Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location must have its own unique NPI.

Please note that regardless of how subparts are determined and NPIs obtained, Medicare payments, by law, may be made only to an enrolled Medicare provider or supplier.

### **Important Medicare NPI Implementation Dates**

#### ***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.

## Final Notes about NPIs

With regard to enrolled organization health care providers or subparts who **bill more than one** Medicare contractor:

- An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor.
- For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

With regard to enrolled organization health care providers or subparts who bill **more than one type** of Medicare contractor:

- Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor.
- In certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as **more than one type of provider**.

For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier, and bills its services to a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill the DME to a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the carrier and the DMERC.

- Medicare expects that this ambulatory surgical center would report two different taxonomies when it applies for its NPI:
  - Ø Ambulatory Health Care Facility—Clinic/Center - Ambulatory Surgical (261QA1903X); and
  - Ø Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization.

With regard to enrolled organization health care providers who determine subparts for **reasons unrelated to** Medicare statutes, regulations or policies:

- Consistent with the NPI Final Rule, covered organization health care providers may designate subparts for reasons that are not necessarily related to Medicare statutes or regulations.
- If a Medicare organization health care provider designates as subparts entities **other than** those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, **those NPIs will not identify enrolled Medicare providers**. Medicare is not required to enroll them.

NPI Final Rule, page 3441 says the following: “If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls.”

## Additional Information

### Medicare’s NPI Responsibilities

Medicare will:

- Use NPIs to **identify** health care providers and subparts in HIPAA standard transactions;  
NPI Final Rule, page 3469: section 162.412(a): “A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider’s identifier is required.”
- Ensure that the NPIs it receives in HIPAA standard transactions are valid;
- Reject HIPAA standard transactions that contain invalid NPIs.

Valid NPIs, however, like the provider identifiers used today, must be “known” to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

***Related Links***

In preparation for the release of the Electronic File Interchange (EFI) system, CMS released several documents on the EFI process. EFI, also referred to as “bulk enumeration,” is a process by which a health care provider or group of providers can have a particular organization (the “EFIO”) apply for NPIs on their behalf.

EFI documents posted to the web include a summary, user’s guide, and technical companion manual. Visit [http://www.cms.hhs.gov/NationalProvIdentStand/07\\_efi.asp](http://www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp) to download these new items.

NPI-related information, including how to apply for an NPI and a new fact sheet for health care providers who are individuals, is available on the CMS web site at:

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

The NPI Final Rule can be found on the CMS web site at:

<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf>

## Oncology

### 2006 Oncology Demonstration Project - Inclusion of Gynecological Oncology

Reference: *Trans. 41, CR #4347, Pub. 100-19, Medlearn Matters Number: MM4347*

**Note:** This article was revised on March 13, 2006, to reflect revisions made to CR4347, which was reissued on March 10 as Transmittal 41. CR4347 was revised because the specialty code for medical oncology should have shown as 90 (not 83) and for hematology/oncology should have shown as 83 (not 90).

#### **Provider Types Affected**

Gynecological oncologists who bill Medicare for office-based oncological services

#### **What You Need to Know**

CR4347 (from which this article was taken) adds gynecological oncologists to the list of physician specialties qualified to participate in the 2006 Oncology Demonstration Project.

#### **Background**

CMS initiated a one-year oncology demonstration project for 2006 designed to identify and assess particular oncology office practice-based services that improve outcomes in the Medicare population (as stated in CR4219, Transmittal 36, *2006 Oncology Demonstration Project*, issued on December 30, 2005).

That CR included the physician specialties of hematology (82), medical oncology (90), and hematology/oncology (83), as qualifying under the 2006 oncology demonstration.

In CR4347, CMS adds the specialty of gynecological oncology (98) to this list. Therefore, unless otherwise noted, the policy, instructions, messages, and business requirements in CR4219 apply equally to gynecological oncology.

Your carriers will not search their records for claims previously submitted for gynecological oncology services in 2006 that were denied payment under the oncology demonstration. They will, however, adjust claims that are brought to their attention.

#### **Additional Information**

You can find more information about the inclusion of gynecological oncologists in the 2006 Oncology Demonstration Project by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R41DEMO.pdf>

In addition, you can learn more about the 2006 Oncology Demonstration Project itself by reading *MedLearn Matters* article MM4219. This article is on the CMS web site at:

<http://www.cms.hhs.gov/MedLearnMattersArticles/downloads/MM4219.pdf>

If you have any questions, please contact your carrier at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## 2006 Oncology Demonstration Project

Reference: Trans. 42, CR #4219, Pub. 100-19, Medlearn Matters Number: MM4219

**Note:** This article was revised on March 13, 2006, to reflect revisions made to CR4219, which was reissued on March 10 as Transmittal 42. The CR4219 was revised because the specialty code for medical oncology should have shown 90 (not 83) and for hematology/oncology should have shown 83 (not 90).

### **Provider Types Affected**

Hematologists and oncologists who bill Medicare for the care of cancer patients

### **Provider Action Needed**

This article provides information on the oncology demonstration project for 2006. Additional information and guidance is available in *Medlearn Matters* article SE0588, which is available on the Centers for Medicare & Medicaid Services' (CMS) web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf>

### **Background**

The Social Security Act Amendments of 1967 (Pub. L. 90-248, Sections 402(a) (1) (B) and 402(b)), give the Secretary of Health and Human Services the authority to develop and implement experiments and demonstration projects to:

- Provide incentives for economy, while
- Maintaining or improving quality in health services delivery.

In this context, CR4219, upon which this article is based, announces the implementation of the Medicare oncology demonstration project for 2006. This one-year demonstration project's purpose is to identify and assess, in office-based oncology practices, certain oncology services that positively affect outcomes in the Medicare population.

This 2006 oncology demonstration project replaces the 2005 chemotherapy demonstration project, and substantially changes the reporting emphasis. In the 2006 project, your reporting will no longer be specific to chemotherapy administration services, but, instead, will be associated with physician evaluation and management (E & M) visits for established patients with cancer.

The project builds on the use of G-codes (temporary national codes for items or services requiring uniform national coding between one year's update and the next) to gather more specific information about patients with particular types of cancer (noted below), including information about the primary focus of the visit and the spectrum of care that you provide.

It will emphasize practice guidelines as the source for standards of care, permitting CMS to monitor and encourage quality care to cancer patients, and to identify and promote best cancer care practices that should lead to improved patient outcomes.

This purpose is facilitated by the elimination of some G-codes and the adoption of new ones. Calendar year 2005 G-codes (G0921 to G0932), specific to the assessment of patient symptoms, have been eliminated, effective December 31, 2005.

### **G-Codes Address Three Reporting Categories**

To facilitate the collection of the oncology demonstration information, CMS has established 81 new G-codes that address three reporting categories:

1. The primary focus of the evaluation and management visit;
2. Whether current management adheres to clinical guidelines; and
3. The current disease state.

Capturing these variables will form the building blocks of efficiency-oriented demonstrations in the future. You can find these new G-codes in the table at the end of this article.

### **Diagnostic Categories**

Office-based hematologists and oncologists can participate in this demonstration, for services they furnish in 2006, when they provide an evaluation & management (E & M) service of level 2, 3, 4, or 5 to an established patient

(American Medical Association's Current Procedural Terminology (CPT) codes 99212, 99213, 99214 and 99215) with a primary diagnosis of cancer belonging to one of the following 13 major diagnostic categories:

1. Head and neck cancer (140.0 –149.9, 161.0-161.9)
2. Esophageal cancer (150.0-150.9)
3. Gastric cancer (151.0-151.9)
4. Colon cancer (153.0-153.9)
5. Rectal cancer (154.0, 154.1)
6. Pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9)
7. Lung cancer (both non-small cell and small cell) (162.2-162.9)
8. Female breast cancer (invasive) (174.0-174.9)
9. Ovarian cancer (183.0)
10. Prostate cancer (185)
11. Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)
12. Multiple myeloma (203.00, 203.01)
13. Chronic myelogenous leukemia (205.10, 205.11)

### **To Qualify for the Payment**

To qualify for the payment associated with this demonstration payment, you must submit one G-code from each of the three categories mentioned above when you bill for an E & M of level 2, 3, 4, or 5 for established patients. Practices reporting data on all three categories will qualify for an additional oncology demonstration payment of \$23 in addition to the E & M visit.

### **Important Details**

The following are some important details that you should be aware of:

#### **Participation is Voluntary**

Participation in this demonstration is voluntary and the physician participates by filing a claim for services (i.e., a level 2, 3, 4, or 5 established office visit with three separate G codes, one from each category) with the Medicare carrier.

#### **Qualifying Specialties**

The physician specialties that qualify for this 2006 oncology demonstration are hematology (specialty code 82), medical oncology (specialty 90), and hematology/oncology (specialty 83).

Midlevel practitioners, such as nurse practitioners or others who may bill independently for Medicare services, are not eligible to participate in the demonstration. Medicare carriers will deny claims for the 2006 oncology demonstration submitted by other than a qualifying specialty. Such claims will be denied with remittance advice code N95 and claim adjustment reason code 185.

#### **Other Cancer Types Not Included**

E & M services that you furnish for patients with cancer types as the principal diagnosis, other than these mentioned in this CR, will not be included in the demonstration. If you report claims with these demonstration G codes that are not related to the 13 specific cancer types, those G codes will be denied.

#### **Applies to Beneficiaries Not Enrolled in Medicare Advantage Plan**

The project applies only to Medicare beneficiaries who are not enrolled in a Medicare Advantage plan, and is effective only for services provided on or after January 1, 2006, and before January 1, 2007. Medicare carriers will return/reject, as not able to process, oncology demonstration G-codes that are billed for dates of service not within CY 2006, using Remittance Advice reason code B18 and remark code N56 and Medicare Summary Notice (MSN) message 16.13.

#### **Chemotherapy**

While chemotherapy may be provided to the patient on the same day as the E & M visit, it is only the latter that is linked to the demonstration project. In this instance, therefore, you should attach modifier 25 to the E & M service. This denotes that you have performed a significant, separately identifiable evaluation and management service on

the same day of a procedure (the chemotherapy administration service). Further, you should appropriately document the patient's record to support the level of the E & M service billed.

### **Billing Codes**

You must bill a code from each of the three categories mentioned above. If you bill one or more (but not one from all three categories) of the demonstration codes on a single claim, carriers will return/reject the claim as not able to process and use Remittance Advice reason code 16 and remark code MA 130.

Conversely, if you bill more than one G-code from the same category for the same date of service on the same claim (for instance, you submit a claim for more than two G-codes from the category of "primary focus of the visit"), carriers will also reject the claim as not able to process, and use remittance advice reason code 125 and remittance advice remark code MA130.

**Note:** Some Medicare carriers may choose to manually split the claim and only return the not able to process portion (i.e., the portion related to submitting data for the oncology demonstration). However, CMS will not require carriers to do this.

### **Claims Must Be Assigned**

Your claims must be assigned. If a participating provider submits a non-assigned claim for the oncology demonstration G codes, carriers will process the claim as assigned and generate Remittance Advice remark code MA09.

If a nonparticipating provider submits a non-assigned claim for the G-codes and related E & M service, carriers will process the claim for coverage and payment of those services that do not require assignment (e.g., the evaluation and management service) and deny the G-codes using Remittance Advice reason code 111, remark code N149, and MSN message 16.6.

### **Resubmitting G-Codes**

Providers may resubmit oncology demonstration G-codes that were denied for not accepting assignment and, in such instances, the G-codes will be approved if the related E & M codes were approved. However, if there is no approved E & M code for the same service date and place of service as the G-codes on the claim or in the history, carriers will deny the G-codes using Remittance Advice reason code 107 and MSM code 16.26.

### **Place of Service**

The place of service reported for codes must be "office" (place of service code 11). If the place of service reported is other than "office," carriers will return/reject the claim as not able to process using Remittance Advice reason code 5 and MSN code 16.2.

### **Payment Allowances**

Carriers will establish the following payment allowances for the demonstration codes and determine payment based on the lesser of 80% of the actual charge or on the allowance by code:

- G9050 to G9055 - \$7.67
- G9056 to G9062 - \$7.67
- G9063 to G9130 - \$7.66

These amounts apply in all localities, and the usual Part B coinsurance and deductible apply.

### **SNF Consolidated Billing**

During the demonstration, the oncology G-codes will bypass SNF consolidated billing for beneficiaries in a Part A stay.

### **Additional Information**

The new 2006 oncology G codes and their descriptors can be viewed beginning on the next page of this article.

In addition, a special edition *Medlearn Matters* article is available to provide additional coding guidance. That article is available on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf>

To view the actual instruction, CR4219, issued to your carrier, visit the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R42DEMO.pdf>

If you have any questions, please contact your carrier at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

### Oncology Demonstration Project G-codes (in Numerical Order by Code)

| Category/G-code  | Description  |
|--|--|
| <b>Primary focus of the visit</b>  |  |
| G9050  | Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (For use in a Medicare-approved Demonstration Project)   |
| G9051  | Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy                                |
| G9052  | Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future                          |
| G9053  | Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future  |
| G9054  | Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies |
| G9055  | Oncology; primary focus of visit; other, unspecified service not otherwise listed  |
| <b>Guideline Adherence Codes</b>   |  |
| G9056  | Oncology; practice guidelines; management adheres to guidelines  |
| G9057  | Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial   |
| G9058  | Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations  |
| G9059  | Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management including no treatment  |
| G9060  | Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines  |
| G9061  | Oncology; practice guidelines; patient's condition not addressed by available guidelines   |
| G9062  | Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed   |
| <b>Disease Status Codes</b>  |  |
| <b>Lung cancer, Non-small cell, small cell lung cancer (162.2-162.9)</b> |  |
| G9063  | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage I (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence metastases   |
| G9064  | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage II (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases  |
| G9065  | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established stage III A (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases  |
| G9066  | Oncology; disease status; limited to non-small cell lung cancer; stage III B- IV at diagnosis, metastatic locally recurrent, or progressive  |
| G9067  | Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, under evaluation, not yet determined, or not listed  |

|   |  |
|---|--|
| G9068                                     | Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases  |
| G9069                                     | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive  |
| G9070                                     | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non small; extent of disease unknown, under evaluation, pre-surgical, or not listed  |
| <b>Female breast cancer (174.0-174.9)</b> |  |
| G9071                                     | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ adenocarcinoma as predominant cell type; stage I or stage IIA-IIB; or T3, N1, M0; and ER and/or PR positive with no evidence of disease progression, recurrence, or metastases  |
| G9072                                     | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage I, or stage IIA-IIB; or T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases |
| G9073                                     | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage IIIA-IIIIB; and not T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recurrence, or metastases  |
| G9074                                     | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage IIIA-IIIIB; and not T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases     |
| G9075                                     | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive   |
| G9076                                     | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; extent of disease unknown, under evaluation, pre-surgical or not listed  |
| <b>Prostate cancer (185)</b>              |  |
| G9077                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T1-T2C and Gleason 2-7 and PSA < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases   |
| G9078                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T2 or T3A† Gleason 8-10 or PSA > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases   |
| G9079                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T3B-T4, any N; any T, N1 at diagnosis with no evidence of disease progression, recurrence, or metastases  |
| G9080                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising PSA or failure of PSA decline  |
| G9081                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma; non-castrate, incompletely castrate; clinical metastases or M1 at diagnosis  |
| G9082                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma; castrate; clinical metastas or M1 at diagnosis   |
| G9083                                     | Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, under evaluation or not listed  |
| <b>Colon cancer (153.0-153.9)</b>         |  |
| G9084                                     | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-3, N0, M0 with no evidence of disease progression, recurrence, or metastases  |

|  |  |
|--|--|
| G9085                                  | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T4, N0, M0 with no evidence of disease progression, recurrence, or metastases  |
| G9086                                  | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-4, N1-2, M0 with no evidence of disease progression recurrence, or metastases   |
| G9087                                  | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic or biochemical evidence of disease   |
| G9088                                  | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease   |
| G9089                                  | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, not yet determined, under evaluation, pre-surgical, or not listed  |
| <b>Rectal cancer (154.0, 154.1)</b>    |  |
| G9090                                  | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-2, N0, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases                 |
| G9091                                  | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T3, N0, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases                   |
| G9092                                  | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-3, N1-2, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases                |
| G9093                                  | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases                |
| G9094                                  | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive   |
| G9095                                  | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, not yet determined, under evaluation, pre-surgical, or not listed   |
| <b>Esophageal cancer (150.0-150.9)</b> |  |
| G9096                                  | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T1-T3, N0-N1 or NX (prior to neo-adju therapy, if any) with no evidence of disease progression, recurrence, or metastases |
| G9097                                  | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases  |
| G9098                                  | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive   |
| G9099                                  | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, not yet determined, under evaluation, pre-surgical or not listed  |

| <b>Gastric cancer (151.0-151.9)</b>                    |   |
|--|---|
| G9100  | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post R0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression or metastases   |
| G9101  | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post R1 or R2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases  |
| G9102  | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic M0, unresectable with no evidence of disease progression, or metastases  |
| G9103  | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic M1 at diagnosis, metastatic, locally recurrent, or progressive   |
| G9104  | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, under evaluation, not yet determined, pre-surgical, or not listed  |
| <b>Pancreatic cancer (157.0-157.3, 157.8, 157.9)</b>   |   |
| G9105  | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post R0 resection without evidence of disease progression, recurrence, or metastases   |
| G9106  | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; Post R1 or R2 resection with no evidence of disease progression, or metastases  |
| G9107  | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, M1 at diagnosis, metastatic, locally recurrent, or progressive   |
| G9108  | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, under evaluation, not yet determined, pre-surgical, or not listed  |
| <b>Head and neck cancer (140.0-149.9, 161.0-161.9)</b> |   |
| G9109  | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as T1-T2 and N0, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases     |
| G9110  | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as T3-4 and/or N1-3, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases |
| G9111  | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive   |
| G9112  | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, not yet determined, pre-surgical, or not listed   |
| <b>Ovarian cancer (183.0)</b>                          |   |
| G9113  | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage IA-B (grade 1) without evidence of disease progression, recurrence, or metastases  |
| G9114  | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage IA-B (grade 2-3); or stage IC (all grades); or stage II; without evidence of disease progression, recurrence, or metastases  |
| G9115  | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage III-IV; without evidence of progression, recurrence or metastases  |
| G9116  | Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance  |
| G9117  | Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, evaluation, incomplete surgical staging, pre-surgical staging, or not listed   |

| <b>Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)</b> |   |
|--|---|
| G9118  | Oncology; disease status; non-hodgkin's lymphoma, limited to follicular lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, small lymphocytic lymphoma; stage I, II at diagnosis, not relapsed, n refractory                                     |
| G9119  | Oncology; disease status; non-hodgkin's lymphoma, limited to follicular lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, small lymphocytic lymphoma; stage III, IV not relapsed, not refractory   |
| G9120  | Oncology; disease status; non-hodgkin's lymphoma, transformed from follicular lymphoma to diffuse large B-cell lymphoma   |
| G9121  | Oncology; disease status; non-hodgkin's lymphoma, limited to follicular lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, small lymphocytic lymphoma; relapsed/ refractory   |
| G9122  | Oncology; disease status; non-hodgkin's lymphoma, limited to follicular lymphoma, mantle cell lymphoma diffuse large B-cell lymphoma, peripheral T-cell lymphoma or small lymphocytic lymphoma; stage III, IV at diagnostic not relapsed and not refractory |
| <b>Chronic Myelogenous leukemia (205.10, 205.11)</b>         |   |
| G9123  | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or BCR-ABL positive; chronic phase not in hematologic, cytogenetic, or molecular remission  |
| G9124  | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or BCR-ABL positive; accelerated phase not in hematologic cytogenetic, or molecular remission  |
| G9125  | Oncology; disease status; chronic mylogenous leukemia, limited to philadelphia chromosome positive /or BCR-ABL positive; <i>blast phase not†</i> in hematologic, cytogenetic, or molecular remission  |
| G9126  | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or BCR-ABL positive; in hematologic, cytogenetic, or molecular remission   |
| G9127  | Oncology; disease status; chronic meylogenous leukemia, limited to philadelphia chromosome positive and /or BCR-ABL positive; extent of disease unknown, under evaluation, not listed (for use in a medic approved demonstration project                    |
| <b>Multiple Myeloma (203.00, 203.01)</b>                     |   |
| G9128  | Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, stage I  |
| G9129  | Oncology; disease status; limited to multiple myeloma, systemic disease; stage II or higher   |
| G9130  | Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown under evaluation, or not listed  |

† Italicized text reflects impending change to long descriptor to be implemented in January 2006. The coding physician should assume the long descriptor includes this change.

## *Prescription Drug Coverage*

### **2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries - The Twelfth in the Medlearn Matters Series on Drug Plans**

*Reference: Medlearn Matters Number: SE0618*

#### ***Provider Types Affected***

Physicians, providers, and suppliers, and their staff who provide service to people with Medicare

#### ***Important Points to Remember***

- Key points to remember about the new Medicare prescription drug coverage include the following:
- Beneficiaries can join a Medicare Prescription Drug Plan that covers prescription drugs only and keep their Original Medicare coverage. Or, they can join a Medicare Advantage Plan or other Medicare Health Plan that covers doctor and hospital care as well as prescriptions.
- Medicare prescription drug coverage is NOT automatic - people must join a plan to get coverage
- Your patients have an initial opportunity to join a Medicare drug plan now through May 15, 2006.
- Most people will have to pay a higher premium that includes a penalty if they wait to join a Medicare drug plan until after May 15, 2006, unless they have other coverage that, on average, is at least as good as Medicare prescription drug coverage.

This penalty consists of an additional 1% of the base premium for every month the person went without coverage, and is levied as long as the person is enrolled in a Medicare drug plan.

- People who do not join a Medicare drug plan by May 15, 2006, may also have to wait until November 15, 2006 for their next opportunity to join.

If your Medicare patients ask you questions about the new coverage, you can refer them to <http://www.medicare.gov> and 1-800-MEDICARE for additional information and assistance.

#### ***General Information***

One of the issues that may be most important for your patients involves what Medicare prescription drug coverage means to them in terms of cost. This article focuses on the out-of-pocket expenses that your patients will incur under this new program and highlights the costs covered by a standard plan.

Actual costs of the specific Medicare Prescription Drug Plans and the Medicare Advantage Plans or other Medicare Health Plans in each area are available in the "Medicare & You 2006" handbook and at <http://www.medicare.gov> on the web.

#### ***Costs Covered by a Standard Plan***

Costs for your patients who join a Medicare drug plan will vary depending on their financial situation and which Medicare drug plan they join. All Medicare drug plans will offer at least the standard level of coverage described below.

Medicare drug plans may design their plans differently as long as what their plan offers is, on average, at least as good as the standard coverage. Some plans may offer more coverage for higher premiums.

Patient costs under standard Medicare drug coverage as defined by the MMA for 2006 will include the following:

- A monthly premium (average of \$32 in 2006);
- A \$250 deductible;
- Person pays, on average, 25% of allowable drug expenses up to a coverage limit of \$2,250 (plan pays the other 75%);
- After \$2,250 in covered drug costs, person pays 100% of covered drug costs until \$3,600 limit in true out-of-pocket spending is reached;
- About 5% coinsurance for covered drug costs after \$3,600 out-of-pocket limit is reached.

Individuals with standard coverage will pay the full cost of their prescriptions for drug spending between \$2,250 and up to their true out-of-pocket limit of \$3,600. However, plan enrollees will still be able to obtain their plan's discounted price for prescription drugs in this coverage gap.

### **Alternate Coverage**

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than \$250, or use tiered co-payments rather than coinsurance – provided that the alternative coverage structure meets certain tests of actuarial equivalence.

Also, plans may offer additional drug coverage that supplements the standard coverage. Medicare payments to plans do not subsidize such supplemental coverage.

### **Costs for Patients with Medicare and Full Medicaid Benefits**

Under Part D, starting in 2006, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100% of the federal poverty level will have Medicare prescription drug coverage with no deductibles, no premiums, nominal co-pays, and no coverage gap.

Beneficiaries who do not qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test, will qualify for extra help paying for Medicare prescription drug coverage. Beneficiaries who qualify for extra help can join a Medicare drug plan with full or partial coverage for premiums and cost-sharing and no coverage gap.

### **Specific Information on Out-of-Pocket Expenses**

#### ***Medicare Drug Plan Premiums***

Medicare drug plan monthly premiums vary, depending on the plan; however:

- All regions of the country have multiple plan options with premiums significantly below \$30.
- There will be at least one prescription drug plan with a premium below \$20 per month in every region of the country except Alaska.
- The average monthly beneficiary premium is \$32.20, about \$384 per year.

#### ***True Out-Of-Pocket Costs***

The cost to beneficiaries with Medicare for Medicare prescription drug coverage over and above the monthly premium is often referred to as “true out-of-pocket expenses” or TrOOP.

The TrOOP represents the amount a beneficiary must spend on Part D covered drugs until catastrophic coverage begins. That catastrophic coverage begins when the beneficiary's out-of-pocket expenses reach \$3,600 in a year.

In addition to paying the base premium for their plan, Medicare beneficiaries will also pay TrOOP costs including the following:

- A deductible amount (\$250) and coinsurance (25% of covered drug costs during the plan payment + coinsurance stage);
- All costs during the coverage gap stage; and
- Five percent of covered drug costs during the catastrophic coverage stage.

These additional TrOOP expenses are explained as follows:

#### ***Deductible (From \$0 to \$250: A net value of \$250)***

Under standard coverage, plan enrollees pay a \$250 deductible each calendar year out of their own pockets for Part D covered drugs.

#### ***Plan Payments + Coinsurance (From \$251 to \$2250)***

Once the annual (\$250) deductible is met, standard coverage pays for 75% of the next \$2,000 (or up to \$1,500) for covered (allowable) drugs and biologicals. The remaining 25% (a maximum of \$500) of the cost is covered by the beneficiary via coinsurance/co-payments.

#### ***Coverage Gap (From \$2,251 to \$3,600 TROOP limit)***

Once covered drug costs have reached the plan payment + coinsurance + deductible limit of \$2,250, the plan does not pay again until the plan enrollee has reached the \$3,600 limit in out-of-pocket spending. The beneficiary pays

all covered drug costs incurred in this “gap.” The total out of pocket cost (not including premiums) to this point (deductible + plan payments + coinsurance + coverage gap) is \$3,600 for coverage through the full “gap” (see TrOOP discussion below.)

#### ***Catastrophic Coverage (Costs over \$3,600 TROOP limit)***

Once the individual’s true out-of-pocket spending reaches \$3,600, costs for necessary covered drugs are covered as follows:

- Reinsurance – 80% of covered drug-related costs are covered by Medicare;
- Plan payments – 15% of covered drug-related costs are covered by the drug plan;
- Coinsurance – 5% of covered drug-related costs are covered by the individual.

#### ***What Counts Toward True Out-of-Pocket (TrOOP) Costs?***

Beneficiaries must adhere to their plan’s formulary, prior authorization, and formulary exceptions processes in order for their out-of-pocket spending to count toward the \$3,600 limit.

The following types of spending count toward the \$3,600 threshold:

- The beneficiary’s own out-of-pocket spending;
- Spending by a family member or official charity, on behalf of the beneficiary;
- Supplemental drug coverage provided through qualifying state pharmacy assistance programs (SPAP) or Medicare’s extra help; and
- Under the Centers for Medicare & Medicaid Services’ (CMS’) demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

In summary, the amount that a beneficiary must spend on part D-covered drugs until catastrophic coverage is reached, based on the 2006 standard coverage, is as follows:

\$250 deductible  
+ \$500 plan enrollee coinsurance during initial coverage  
+ \$2,850 coverage gap  
= \$3,600 (plus the monthly premium, which averages \$384/year)

Once this cost has been reached for covered drugs, catastrophic coverage begins.

#### ***Related Links***

HHS Secretary Mike Leavitt recently released a two-month progress report on Medicare Prescription Drug Coverage that takes a hard look at what is working and what needs to improve. To view the report, visit:

<http://www.hhs.gov/medicare2final.pdf>

For more information about *Medicare Prescription Drug Coverage for Providers*, visit [http://www.cms.hhs.gov/MedlearnProducts/23\\_DrugCoverage.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage) on the CMS web site.

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## **Prescription Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference**

*Reference: JSM CI 3783-06312, 03-03-06*

NEW! Visit [www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp) and scroll down to “Part D Tools for Health Care Professionals” for a comprehensive list of links to agency-wide resources for providers on Medicare Rx coverage. These resources can help providers and office staff access direct phone numbers to a Medicare drug plan’s coverage determination staff, as well as obtain model forms that will help speed the process. Additionally, a new fact sheet, as well as other educational products for the FFS community, is now available at [www.cms.hhs.gov/medlearn/drugcoverage.asp](http://www.cms.hhs.gov/medlearn/drugcoverage.asp) on the CMS website.

# Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference

Reference: Medlearn Matters Number: SE0619

## **Provider Types Affected**

Providers, physicians, and suppliers and their staff who prescribe medications for Medicare patients

## **Key Points**

The Centers for Medicare & Medicaid Services (CMS) has developed three new products as part of the Medicare Prescription Drug Coverage (Part D) campaign for health care professionals:

## **Consolidated List of Links**

A consolidated list of links to resources for prescribers is located on the CMS web site at:

<http://www.cms.hhs.gov/center/provider.asp>

At this web page, offices can get access to direct telephone numbers to a Medicare drug plan's coverage determination staff, as well as to obtain model forms that will help speed this process.

Educational information for Fee-For-Service (FFS) providers is always available through our Medicare Learning Network drug coverage page on the CMS web site at:

[http://www.cms.hhs.gov/MedlearnProducts/23\\_DrugCoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp)

## **Transition Policy Fact Sheet**

A new fact sheet regarding the new transition policy, as well as the exceptions and appeals process for Medicare Prescription Drug Coverage, is available for use in prescriber offices. This resource fact sheet provides ready links to tools that will streamline the prescribing process under the new coverage.

CMS continues to work with groups representing physicians, pharmacists, patients, and Part D plans to simplify and standardize the information that physicians need to provide to plans.

The fact sheet is on the CMS web site at:

[http://www.cms.hhs.gov/MedlearnProducts/downloads/Part\\_D\\_Resource\\_Factsheet.pdf](http://www.cms.hhs.gov/MedlearnProducts/downloads/Part_D_Resource_Factsheet.pdf)

## **An Important Message for Providers Regarding Medicare Part D from CMS Administrator Dr. Mark McClellan**

Dr. McClellan's message to providers describes the steps CMS is taking to implement the new Medicare prescription drug coverage. Dr. McClellan also discusses helpful resources for providers. Streaming video of this message is available on the CMS web site at:

<http://media.cms.hhs.gov/cms/McClellanPartDProvider.wmv>

## **Phone Conference Training Session**

A PowerPoint presentation and audio replay of a recent phone conference training session is available, entitled "*Working with Plan Formularies: Transition Supplies, Prior Authorization, Quantity Limits, Step Therapy, and Exceptions.*"

This training session is geared towards guiding office staff through the exceptions process. These materials are located on the CMS web site at:

<http://media.cms.hhs.gov/cms/partner03022006.wma>

## **Other Special Edition Articles**

Other special edition articles regarding the prescription drug program include, but are not limited to, the following:

- SE0618 – "2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries," available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0618.pdf> on the CMS web site.
- SE0603 – "Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals – The Eleventh in the Medlearn Matters Series on the New Prescription Drug

Plans,” available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0603.pdf> on the CMS web site.

- SE0557 – “Clarification on Part D and Fee-for-Service (FFS) Providers,” available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0557.pdf> on the CMS web site.
- SE0502 – “The Facts for Providers Regarding the Medicare Prescription Drug Program,” available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0502.pdf> on the CMS web site.

## *Provider Enrollment*

### **Provider Enrollment in the Medicare Program**

*Reference: Medlearn Matters Number: SE0612*

#### ***Provider Types Affected***

All Medicare physicians, providers, and suppliers

#### ***What You Need To Know***

- You must enroll in the Medicare program in order to receive Medicare payment for covered services that you provide to Medicare beneficiaries.
- The Medicare enrollment application and process are used to collect information about you and to secure the necessary documentation to ensure you are qualified and eligible to enroll in the Medicare program.
- This Special Edition article (SE 0612) contains helpful information about the Medicare enrollment process.

#### ***Background***

Physicians, providers, and suppliers must enroll in the Medicare program in order to receive Medicare payment for services provided to its beneficiaries.

You can accomplish this enrollment by completing the Medicare enrollment application, in which you provide the information and supporting documentation needed to ascertain your qualifications for, and your eligibility to enroll in, the Medicare program.

When submitted, a designated Medicare fee-for-service contractor (known as a carrier or fiscal intermediary [FI]) will process your application and verify the information that you have provided.

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing. Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application

To obtain a list of specific supporting documentation that you must submit with your enrollment application, call or visit the Medicare fee-for-service contractor serving your area (see *Additional Information* section below.)

Be aware that, at any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application.

Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

#### ***Additional Information***

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS web site.

## ***Religious Non-Medical Health Care Institution (RNHCI)***

### **Revisions to Instructions for Contractors Other Than the Religious Non-medical Health Care Institutions (RNHCI) Specialty Contractor Regarding Claims for Beneficiaries with RNHCI Elections**

*Reference: Trans. 35, 45 and 851, CR #4218, Pub. 100-01 100-02 and 100-04, Medlearn Matters Number: MM4218*

#### ***Provider Types Affected***

Physicians, providers, and suppliers who may treat Medicare patients who have elected RNHCI care and bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for those services.

#### ***Impact to You***

This change request (1) replaces the current process that develops claims via telephone inquiry for beneficiaries with RNHCI elections with a letter using “yes” or “no” questions; (2) places into the *Medicare Claims Processing Manual* RNHCI claims processing instructions; (3) restructures much of the existing RNHCI manual material to be more complete and accessible; (4) defines the RNHCI; and (5) lists the qualifying criteria for RNHCI benefits.

#### ***What You Need to Know***

Note the business requirements in this CR that apply to your billing area.

#### ***What You Need to Do***

For providers other than RNHCIs, use the letter issued by your contractor that asks questions key to determining excepted versus non-excepted care. For RNHCIs, incorporate the new claims submission instructions into your billing procedures.

#### ***Background***

The transmittal publishes enhancements to Medicare manuals to more clearly explain the RNHCI benefit. The majority of these manual changes do not create any new business requirements. However, the transmittal revises instructions from Program Memorandum (PM) AB-03-145.

That PM changed the development process for claims for beneficiaries with RNHCI elections from a review of medical records to a telephone contact process. The intent of PM AB-03-145 was to simplify the development process.

Since the issuance of PM AB-03-145, a number of Medicare contractors (i.e., carriers and fiscal intermediaries) other than the RNHCI specialty contractor have expressed sufficient concerns about the telephone contact process to cause the Centers for Medicare & Medicaid Services (CMS) to revise that process.

Non-specialty contractors with high volumes of RNHCI-related claims rejections, reported difficulty contacting providers. In addition, they reported beneficiaries were not willing or able to supply the necessary information to enable the contractor to determine whether the care was excepted or non-excepted care under RNHCI benefit policies.

These contractors also expressed concerns about the lack of written documentation from the provider in the telephone-based process. To address these concerns without reverting to a review of medical records, CMS has developed the requirements listed below that will be incorporated into the letter issued to providers.

Briefly, if you bill Medicare for services provided to a patient who has elected RNHCI coverage, the following requirements of CR4218 will apply.

#### ***Requirements of CR4218***

##### **Development Letters for Providers Other than RNHCIs**

Upon receipt of a claim rejected by Medicare systems due to an RNHCI election on file for that Medicare beneficiary, contractors must issue a development letter designed to determine whether care was excepted or non-excepted.

Contractors must issue RNHCI development letters that ask questions about the following:

- Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare;
- Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed; and
- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.

The letters will phrase questions in RNHCI to be answered with a Yes or No response. The wording and format of this letter will be based on the experience of your contractor in effectively communicating with their community of providers.

#### **Determinations Based on Development Letter**

- Contractors will make determinations of excepted or non-excepted care based on provider responses to development letters.
- Contractors will make determinations within 30 days of receipt of the provider's response.
- Contractors will make determinations of excepted care when a provider responds 'Yes' to any of the questions in the letter.
- Contractors will make determinations of non-excepted care when a provider responds 'No' to all of the questions in the letter.
- Contractors will make an excepted/non-excepted determination based on the evidence presented by the claim itself if the provider does not reply in a timely manner to the development letter.
- For claims for which no timely response was received, contractors will make a determination of non-excepted care if the claim contains durable medical equipment or prosthetic/orthotic devices.
- For claims for which no timely response was received, contractor staff with a clinical background will use the diagnoses and procedures reported on the claim to make their best determination whether the services were excepted or non-excepted care.
- For claims for which no timely response was received, contractors will make determinations of excepted or non-excepted care within 30 days of the end of the timely response period.

#### **For RNHCI Providers**

CR4218 provides complete instructions for completion of claims to Medicare. RNHCIs should review the instructions in CR4218 and ensure their current billing processes are consistent with these instructions. The "Related Instructions" section of this article provides information on accessing the transmittals that comprise CR4218.

#### **Implementation**

The implementation date for the instruction is May 11, 2006.

#### **Related Instructions**

For a beneficiary to receive benefits under §1821 of the Social Security Act (the Act) and payment under the Medicare program upon admission to a RNHCI and prior to the RNHCI billing for services, the beneficiary must make a written election.

The document detailing the process for a beneficiary to elect RNHCI care or to terminate that election is attached to transmittal R45BP of CR4218. CR4218 may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R45BP.pdf>

The ten qualifying provisions that must be met for a provider to be defined as an RNHCI, as contained in Section 1861 (ss) (1) of the Act for RNHCIs, are defined in transmittal R35GI of CR4218. The transmittal may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R35GI.pdf>

Chapter 3 of the *Medicare Claims Processing Manual*, Inpatient Hospital Billing, was also completely revised and is contained in transmittal R851CP of CR4218. Transmittal R851CP is available on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R851CP.pdf>

***Additional Information***

The official instructions issued to the RNHCI intermediary regarding this change can be found in three parts, i.e., the transmittals parts as shown in the web addresses provided above.

If you have questions, please contact your carrier/intermediary/DMERC at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## Remittance Advice

### Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More

Reference: Trans. 885, CR #4376, Pub. 100-04, Medlearn Matters Number: MM4376

#### Provider Types Affected

All Medicare providers, physicians, suppliers, and qualified non-physician practitioners billing Medicare carriers and durable medical equipment regional carriers (DMERCs)

#### Impact to You

CR4376 provides notice that beginning June 1, 2006, carriers and DMERCs will stop sending standard paper remittance (SPR) advices to you (or a billing agent, clearinghouse, or other entity representing you) if you have been receiving 835s or electronic remittance advice (ERA) transactions, either directly or through a billing agent, clearinghouse, or other entity representing you, for 45 days or more.

#### What You Need to Know

If you need a paper copy of a remittance advice for accounts reconciliation or to forward to secondary/tertiary payers, be aware that the Centers for Medicare & Medicaid Services (CMS) has developed software that gives you a tool to view and print an 835 in a readable format locally on your computer. This software is called Medicare Remit Easy Print (MREP). See the *Additional Information* section of this article to learn how to access MREP software. Your clearinghouse may also offer software that allows you to view and print your remittance advice.

#### What You Need to Do

Make certain that your billing staffs are aware of these changes. Try MREP software to view and print your own remittance and see the benefits for yourself. Or, check with your clearinghouse to see if it provides similar software.

#### Background

The *Medicare Claims Processing Manual*, Chapter 22, Section 40.1, Remittance Advice, describes the instructions issued by CMS to carriers and DMERCs.

The section instructs carriers and DMERCs to eliminate SPRs to those providers/suppliers who were receiving ERA transactions for 45 days or more.

MREP was developed in response to comments CMS received from the provider/supplier community that they need a paper document for accounts reconciliation, and claim submission for secondary/tertiary payments. Providers/suppliers who use the MREP software package have the ability to print paper remittances and reports that can be used to reconcile accounts receivable, as well as to create document(s) that can be included with claim submissions to secondary/tertiary payers. The output of MREP is similar to the current SPR format.

Benefits of using MREP software include the ability to:

#### Save Time and Money

You can print remittance information directly from your computer the day the HIPAA 835 is available. No more time is spent waiting for the mail.

#### Create and Print Special Reports

With MREP, you can run, export, or print several useful reports including:

- Deductible Service Lines Report: Shows claim service lines that have deductible amount.
- Adjusted Service Lines Report: Shows claims within a single remittance that have a claim status 22 (reversed claim).
- Denied Service Lines Report: Shows only claim service lines that have an allowed amount of zero and are associated with a claim that does not have a claim status 22 (reversed claim).

#### Print and Forward Claims for Other Payers

MREP provides the ability to print remittance information for individual or multiple selected claims, and it allows you to forward only those claims that are needed by other payers for secondary payment. You may view and/or

print as many or as few claims as needed. This eliminates the need for you to darken individually identifiable data on the SPR, as you may do today, that does not pertain to the claim for which you are requesting payment.

### **Navigate and View Remittance Information**

MREP organizes and presents information in a manner that makes it easy for you to view. It also provides separate tabs to access the following:

- A list of claims;
- Details for individually selected claims;
- Summary information;
- Glossary information containing Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and their definitions;
- A data view that allows you to look at the various loops and segments containing data in the HIPAA 835; and
- A search function to find claims containing specific information.

**Note:** MREP software will be revised three times per year to accommodate Claim Adjustment Reason and Remittance Advice Remark Code set changes. You can sign up to be notified automatically when a new version of MREP is available at your carrier's/DMERC's web site.

### **Search for Claim(s) Information Quickly and Easily**

MREP's search function can help you find a claim (or multiple claims) based on your customized search criteria. Using it, you can search by names, numbers, and even portions of information such as:

- Health Insurance Claim Number (HICN);
- Beneficiary Last Name;
- Internal Control Number (ICN);
- Beneficiary Account Number;
- Procedure Code;
- Service Date; and
- Rendering Provider Number

**Note:** MREP's search capability provides a powerful way to save time and money when examining remittance information.

### **Eliminate Need for Physical Filing and Storage Space**

MREP software imports a HIPAA 835 (once you have received it from your carrier/DMERC) and saves the information as a separate Import file to help ensure that the original HIPAA 835 file remains intact.

It also provides an easy-to-use method to archive, restore, and delete these Import files as you maintain your remittance records (further reducing the need for physical filing of printed copies and additional storage space).

As you gain familiarity with the MREP software, you will be able to take advantage of the numerous keystroke shortcuts designed to streamline use of the software and save you time while viewing your remittance information.

### **Implementation**

The implementation date for this instruction is June 1, 2006

### **Additional Information**

To learn about more MREP benefits, download the brochure available on the CMS web site at:

[http://www.cms.hhs.gov/MLNProducts/downloads/remit\\_easy\\_print.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf)

Or, you can view Special Edition MLN Matters article SE0611 on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf>

If you have questions, please contact your Medicare carrier/DMERC at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnProducts/downloads/CallCenterTollNumDirectory.pdf>

For more information about the MREP software and how to receive the HIPAA 835, please contact your carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available on the CMS web site at:

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

The official instructions issued to your carrier/DMERC regarding this change can be found on the CMS web site at:

<http://www.cms.hhs.gov/transmittals/downloads/R885CP.pdf>

## Therapy Services

### Documentation Requirements for Therapy Services Including Therapy Cap Exceptions

Reference: AR – DEC 030906

#### General

Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to Part B & Part B of A therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims).

Also in 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant at the request of the individual enrolled under the Part B & Part B of A benefit or a person acting on behalf of that individual, exceptions to therapy caps for services provided during calendar year 2006, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).

Those providers who believe that it is medically necessary for the beneficiary to receive therapy services in excess of the therapy caps for those diagnoses not automatically excepted must submit documentation sufficient to support medical necessity for those services. Therapy services shall be payable when the medical record and the information on the claim consistently and accurately reports covered services. Documentation must be legible, relevant and sufficient to justify the services billed. Services must be covered therapy services provided according to the requirements in Medicare Manuals.

The guidelines presented below identify the minimal requirements/expectations of documentation by providers, suppliers, or beneficiaries submitting claims for payment of any therapy services to Medicare Services. Additional documentation is not required but may be submitted at the provider's discretion. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity, including that they are skilled, rehabilitative services, safe and effective (i.e. progress indicates that the care is effective in the rehabilitation of function), and provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP.

#### Documentation Required

These types of documentation are required to be submitted with any requests for therapy documentation, as well as those services over and above the therapy caps, unless Pinnacle Business Solutions Inc. (PBSI) should request otherwise.

- **Evaluation/Plan of Care (may be one or two documents)** Include the initial evaluation, and any re-evaluations relevant to the episode being reviewed. The initial evaluation or plan of care with an evaluation should document the medical necessity for the course of therapy through objective findings and subjective patient self-reporting based on guidelines of the American Physical Therapy Association, American Occupational Therapy Association, or the American Speech-Language and Hearing Association. Only a clinician may perform an initial assessment, evaluation and re-evaluation or establish a diagnosis or plan of care. (Please see the manual reference listed below for further discussion of content)
- **Certification** (physician/NPP approval of the plan required no later than 30 treatment days after the initial treatment or delayed certification) Initially Medical Review will accept the certification pending the MD or NPP signature, but if additional exception requests are made, there will be an expectation for submission of signed copies of any applicable certifications.
- **Progress Reports** (when treatment exceeds 10 treatment days or 30 calendar treatment day/one month, whichever is less). The progress report provides justification for the medical necessity of treatment. Progress reports should be provided at least once every 10 treatment days or once during an interval whichever is less. Also if all of the elements required in a Progress Report is included at least once during an interval in the encounter notes, then a separate Progress Report is not required. A clinician must personally perform or actively participate in at least one treatment session during the interval of treatment. The Progress Report must be dated within one week of the last date of treatment reported in the evaluation

and Treatment Encounter Notes. (Please see manual reference listed below for content of Progress Report and documentation requirements of those specialties who may be documenting).

- **Treatment Encounter Notes** (may also serve as Progress Reports when required information is included in the Treatment Encounter Notes). Documentation is required for every treatment day, and every therapy service. It must record:
  - Ø Date of treatment;
  - Ø The name of the treatment,
  - Ø Intervention or activity provided,
  - Ø \*Time spent in services represented by timed codes,
  - Ø \*The total treatment time (including the un-timed service codes)
  - Ø The signature and professional identification of the qualified professional who furnished or supervised and list of each person who contributed to treatment during that encounter.
  - Ø If treatment is added or changed during the treatment days between the interval progress notes, the change must be recorded and justified on the medical record, either in the treatment encounter note or the progress note, as determined by the policies of the provider/supplier.
  - Ø Must be dated within one week of the last date of treatment reported in the evaluation and Progress Report.

\*Contractors shall not count each minute for each therapy service relative to each billed treatment code, but shall ascertain that the total number of minutes of treatment for services represented by timed codes is consistent with the number of units billed for those services and that the total minutes of treatment, including un-timed codes, is consistent with the documentation that the services were provided for a reasonable amount of time.

- **For therapy cap exceptions**, records justifying services over the cap. A separate Justification Statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for use of the KX modifier. Justification for treatment must include objective evidence or a clinically supportable statement of expectation that:
  - Ø The patient's condition has the potential to improve or is improving in response to therapy;
  - Ø Maximum improvement is yet to be attained; and
  - Ø There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

Objective evidence consists of standardized patient assessment instruments, outcome measurement tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

For further discussion of content of documentation and documentation requirements (and the above types of documentation) as well as examples please see:

The *Medicare Benefit Policy Manual* revision at <http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf> on the CMS web site



|   |
|---|
| <b>OFFICE USE ONLY:</b><br>PA# _____<br>PA Nurse Initials _____ |
|---|

**Part B**  
**Pinnacle Medicare Services**  
**AR, LA, MO, NM, OK and RI**  
**Therapy Cap Exception Authorization Form**

**FAX COMPLETED FORM TO : Part B Prior Authorization Nurse**  
**Fax Number: (501) 379-4677 Telephone Number: (501) 918-7492**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Provider Name \_\_\_\_\_ Provider ID Number \_\_\_\_\_

**Patient Background Information:**

Date of surgery or accident: \_\_\_\_\_  
 Limitations: \_\_\_ Ambulatory \_\_\_ Non - Ambulatory  
 Aids Needed: \_\_\_ Walker \_\_\_ Cane \_\_\_ Wheelchair \_\_\_ Limbs or Braces \_\_\_\_\_ Other

**Exception Request:**

Initial \_\_\_\_\_ 1<sup>st</sup> Follow up \_\_\_\_\_ other follow up \_\_\_\_\_

The Following Should Be Attached For Any Requests For Therapy Exceptions:

- Evaluation/Plan Of Care
- Certification
- Progress Reports
- Treatment Encounter Notes
- Justification Statement

**Patient Therapy Attendance:** Regular \_\_\_\_\_ Irregular \_\_\_\_\_

Progress Reports Should Support Attendance And Medical Necessity For The Requested Therapy.

**Requested Services:** Procedure Code/Description/ Frequency /Treatment Days

Physical Therapy:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Speech Therapy:

\_\_\_\_\_  
 \_\_\_\_\_

Occupational Therapy:

\_\_\_\_\_  
 \_\_\_\_\_

Length of Plan Service: From: \_\_\_\_\_ To: \_\_\_\_\_

Additional Comments:

\_\_\_\_\_  
 \_\_\_\_\_

Requested By: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_

## Process for the Therapy Cap Exception for Therapy Providers

Reference: AR – DEC 030906

Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). Outpatient rehabilitation services include:

- Physical Therapy – including outpatient speech language pathology:  
Combined annual limit for 2006 is \$1,740; and
- Occupational therapy – Annual limit for 2006 is \$1,740.

In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, exceptions to therapy caps for services provided during calendar year 2006, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).

This process outlined below will be the exception process for those claims that were billed between January 1, 2006 and current that have met the therapy caps and initially denied. It will also outline the process for handling requests for exception to the therapy caps on a routine basis.

- The Carrier LCD AC-02-059 Physical Medicine and Rehabilitation (or any other LCD; NCD applicable to therapy services), will continue to be in effect and is not superseded by the manualization of CR 4364. Functional diagnosis codes from this policy (or other policies/NCD) will continue to be required as the allowable diagnosis code per procedure code. All claims must have at least one diagnosis code from this policy, then one of the condition codes from the Therapy Cap Exception list from CR 4364 Transmittal 855 found at:

<http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>

- **For those claims Denied prior to 3/13/06 with Automatic Exemptions:**

If the claim has a diagnosis that has been deemed automatically exempted, (those diagnosis codes listed **without** an asterisk (\*) in CMS IOM Pub 100-4 Chapter 5 section 10.2.3), and denied prior to 3/13/06, the provider may submit a new claim with the KX modifier appended to the lines of applicable therapy services,

- **For those claims with Automatic Exemptions after 3/13/06**

After 3/13/06, if the claim has a condition that has been deemed automatically exempted, then the provider must append the KX modifier to therapy services without the submission of request or documentation. However, please be reminded that documentation to support services must be available upon request.

**Please note: You must append a KX modifier on all claims identified as a therapy service when a therapy cap exception has been approved or the service meets the guidelines for an automatic exemption. This allows the approved therapy services to be paid even though they are above the cap. Regardless of financial limitations on therapy services, modifiers are required on specific codes. The therapy modifiers GN, GP or GO are currently required on the claim for specific therapy services, and shall be continued to be used. Those codes subject to the therapy cap tracking requirements are listed in a table in the Claims Processing Manual, Chapter 5, section 20(B), “Applicable Outpatient Rehabilitation HCPCS codes.” All claims submitted for coders underlined but without a therapy modifier shall be returned as unprocessable.**

- **For those requests for Manual Exemption prior to 3/13/06:**

If the claim has a diagnosis that is considered a manual exemption, (those diagnosis codes **with** an asterisk (\*) and those additional exceptions for complexity listed in CMS IOM Pub 100-4 Chapter 5 section 10.2.3 and 10.2.3.4) and the claim has denied due to reaching therapy caps prior to 3/15/06, please fax (**fax number 501-379-4677**) a letter for a retrospective request for exemption (including any treatment days left to be performed) with the specific number of treatment days being requested (not to exceed 15 treatment days for each discipline of occupational therapy, speech language pathology and physical therapy) and include the required documentation to support medical necessity.

- **For those requests for Manual Exemption after 3/13/06:**

If the claim has a diagnosis that is considered a manual exemption, (those diagnosis codes **with** an asterisk (\*) and those additional exceptions for complexity listed in CMS IOM Pub 100-4 Chapter 5 section 10.2.3 and 10.2.3.4), please fax (**fax number 501-379-4677**) a letter for a request for exemption with the specific number of treatment days being requested (not to exceed 15 treatment days for each discipline of occupational therapy, speech language pathology and physical therapy) and include the required documentation to support medical necessity.

- There will be certain therapy evaluation codes excepted after the therapy caps are reached. When submitting claims for the necessary evaluation services that exceed the caps, providers and suppliers must attach the KX modifier to evaluation procedures listed in the manual to identify them as an excepted therapy procedure. Please see CR 4364 Transmittal 855 found at: <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> for a list of the evaluation codes excepted.
- In those cases where the provider has no fax or access to a fax machine, arrangements will need to be made by the provider with the prior authorization nurse to send in their request letter and required documentation by certified mail. The provider will need to call the prior authorization nurse at **(501) 918-7492** in order to receive instructions as to where to mail and who to address the mailing in order for it to reach that nurse. Once the contractor has made the appropriate decision based on the documentation received, the appropriate notification letter will be sent by certified mail to the provider. **This process will need to be repeated with each authorization request. Please note: Medical Review will maintain a data base with notations of release to providers to mail request certified. MR will return all un-authorized mail received from any provider, if no pre-arrangements have been made and noted in the Medical Review database.**
- Once the letter requesting additional treatment days and documentation supporting the medical necessity of the treatment are received, the contractor has 10 business days to issue a decision on retrospective as well as authorizing future additional days. Notification will be sent to the provider on this decision as soon as practicable.
- After the contractor has deemed the request for exception as medically necessary and approved the appropriate number of treatment days, the provider will be notified via fax with the appropriate notification letter. It will contain how many retroactive treatment days and additional future treatment days not to exceed 15 per discipline, are approved.
- If additional days are not approved, the contractor will make that decision within 10 business days and notify the provider as soon as practicable using the appropriate standard letter that additional therapy treatment days are disapproved. It will state if the services are found not to be medically necessary, that the decision on that exception request is not an initial determination and therefore does not carry with it administrative appeal rights, and subsequent claims for additional therapy treatment days which are denied, are denied as benefit category denials.
- If the contractor does not issue a decision within 10 business days, the contractor shall be deemed to have found the additional services requested to be medically necessary. In these cases, the contractor shall grant an exception to the therapy cap approving the number of treatment days requested by the provider, not to exceed 15 treatment days per therapy discipline.
- If the contractor makes the determination that the requested services are medically necessary, that determination is binding on the contractor in the absence of :
  - Fraud; or
  - Evidence of misrepresentation of facts presented to the contractor, or
  - A pattern of aberrant billing by a provider.

Should such evidence of fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether the request was approved (either after manual review, or 10 days after the request). The 10-day exception process shall not be applicable to that provider.

- Providers are strongly encouraged to submit their request for prior authorization for additional treatment days over and above the therapy caps prior to the end of the therapy caps or prior to the end of additional treatment days if at all possible. Repeated requests for exception after the therapy cap has been exceeded, (retrospective review), may be subject to medical review related to fraud or abuse

**Numbers to remember:**

To fax in requests for exception and required documentation:

**Attention: Prior Authorization Nurse (Part B)**  
**Fax Number: (501) 379-4677**  
**Telephone Number: (501) 918-7492**

To send in Certified mail (only if no fax access), contact the **Prior Authorization Nurse (Part B)** to receive instructions.

**Reference:**

The CR 4364 is comprised of 3 transmittals containing information concerning the exception process, listing of diagnosis codes, important documentation information and other important information regarding this new process. Please take the time to read and study these references. They are:

1. The *Medicare Benefit Policy Manual* revision at <http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf> on the CMS web site;
2. The *Medicare Claims Processing Manual* revision located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS web site;
3. The *Medicare Program Integrity Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site; and
4. Medlearn Matters Number MM4364 at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4364.pdf> on the CMS web site

If you have any questions concerning this process of information in this article please contact your state's Customer Service Representative at:

|                     |                       |
|---------------------|-----------------------|
| <b>Arkansas</b>     | <b>(866) 345-0274</b> |
| <b>Louisiana</b>    | <b>(866) 567-8419</b> |
| <b>Missouri</b>     | <b>(866) 736-0799</b> |
| <b>New Mexico</b>   | <b>(866) 280-6520</b> |
| <b>Oklahoma</b>     | <b>(866) 280-6520</b> |
| <b>Rhode Island</b> | <b>(866) 801-5304</b> |

## Claims Submission with Prior Authorization for Therapy Cap Exceptions for Therapy Providers

Reference: AR – DEC 030906

- Those Part B Providers submitting electronic claims for therapy cap exceptions and have received prior authorization numbers will submit the authorization number in the 2300/REF02 with a qualifier of G1 in the 2300/REF01. This information can be found on page 227-228 of the ASC X12N 837 (004010X098) Health Care Claim Professional Implementation Guide. The implementation guide is available for download on your state website or under the Download File Center of any one of our other websites.
- For submission of the CMS-1500 (paper claim) the prior authorization number will go in box 23.
- The prior authorization number will be a 7-8 digit number that will allow us to identify those claims that we have reviewed previously and allowed extra treatment days.
- When the beneficiary qualifies for a therapy cap exception, the provider shall add a KX to the therapy HCPCS subject to the cap limits.
  - Ø Those codes subject to the therapy cap tracking requirements are listed in a table in the Claims Processing Manual, Chapter 5, section 20(B), “Applicable Outpatient Rehabilitation HCPCS codes.”
  - Ø The therapy modifiers GN, GP or GO are currently required on the claim for specific therapy services, and shall be continued to be used.
  - Ø By attaching the KX modifier, the provider is attesting that the services billed:
    - Qualified for the cap exception either automatically or by contractor approval; automatic exceptions are diagnosis codes in the Claims Processing Manual, Chapter 5, section 20(B) without an asterisk.
    - Are reasonable and necessary services that require the skill of a therapist; and
    - Are justified by appropriate documentation in the medical record.

Points to remember in this new process:

- Separate requests need to be submitted for exceptions to the combined PT/ SLP cap and the OT cap.
- Ideally, the requests should be made prior to the beneficiary actually meeting the cap to avoid unnecessary beneficiary liability.
- Since the authorizations do not exceed 15 additional treatment days, a provider must submit a new exception request when the beneficiary is expected to require more therapy than already approved. The services paid will be tracked and claims exceeding the approved treatment days will be denied.
- Those codes subject to the therapy cap tracking requirements are listed in the table in the “Claims Processing Manual”, Chapter 5, Section 20(B), “Applicable Outpatient Rehabilitation HCPCS codes”.
- In those cases where the provider has no fax or access to a fax machine, arrangements will need to be made by the provider with the prior authorization nurse to send in their request letter and required documentation by certified mail. The provider will need to call the prior authorization nurse at **501-918-7492** in order to receive instructions as to where to mail and who to address the mailing in order for it to reach that nurse. Once the contractor has made the appropriate decision based on the documentation received, the appropriate notification letter will be sent by certified mail to the provider. **This process will need to be repeated with each authorization request. Please note: Medical Review will maintain a data base with notations of release to providers to mail request certified. MR will return all un-authorized mail received from any provider, if no pre-arrangements have been made and noted in the Medical Review database.**

If you have any questions concerning this process of information in this article please contact your Customer Service Representative at:

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| Louisiana    | (866) 567-8419 |
| Missouri     | (866) 736-0799 |
| New Mexico   | (866) 280-6520 |
| Oklahoma     | (866) 280-6520 |
| Rhode Island | (866) 801-5304 |

# Annual Update to the Therapy Code List

Reference: Trans. 805, CR #4226, Pub. 100-04, Medlearn Matters Number: MM4226

## **Provider Types Affected**

Private practicing therapists, physicians, suppliers, and providers of therapy services billing Medicare carriers and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for rehabilitation therapy services

## **Impact to You**

This article is based on Change Request (CR) 4226, which implements policy changes discussed in the Outpatient Prospective Payment System (OPPS) final rule for Calendar Year (CY) 2006 and the Medicare physician fee schedule (MPFS) final rule for CY2006.

## **What You Need to Know**

CR4226 describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology. It also updates the list of codes that sometimes or always describe therapy services and their associated policies.

## **What You Need to Do**

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

## **Background**

The Social Security Act (Section 1834(k)(5)) requires that all claims for outpatient rehabilitation therapy services and all Comprehensive Outpatient Rehabilitation Facility (CORF) services be reported using a uniform coding system.

The Healthcare Common Procedure Coding System/Current Procedural Terminology, 2006 - Fourth Edition (HCPCS/CPT-4), is the coding system used for the reporting of these services.

The uniform coding requirement in the Social Security Act is specific to payment for all CORF services and outpatient rehabilitation therapy services that are provided and billed to carriers and fiscal intermediaries (FIs) including:

- Physical therapy;
- Occupational therapy; and
- Speech-language pathology.

Section 1834(k)(5) of the Social Security Act can be found at [http://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)

The Medicare Physician Fee Schedule (MPFS) is used to make payment for these therapy services at the non-facility rate. The following “providers of therapy services” must bill the FI/RHHI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A<sup>1</sup> stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care<sup>2</sup> (POC));
- Comprehensive outpatient rehabilitation facilities (CORFs); and
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient rehabilitation facilities).

<sup>1</sup> The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

<sup>2</sup> For HHAs, HCPCS/CPT coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a Home Health plan of care.

The following practitioners must bill the carriers for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- Physical therapists in private practice (PTPPs);
- Occupational therapists in private practice (OTPPs);
- Physicians, including MDs, DOs, podiatrists and optometrists; and
- Certain non-physician practitioners (NPPs), acting within their state scope of practice, e.g., nurse practitioners and clinical nurse specialists.

### CR4226 Requirements

Change Request (CR) 4226:

- Describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology;
- Updates the list of codes that sometimes or always describe therapy services and their associated policies; and
- Reflects policy changes implemented in (a) the Outpatient Prospective Payment System (OPPS) final rule for CY 2006 and (b) the Medicare Physician Fee Schedule (MPFS) final rule for CY 2006.

Other policies contained in CR4226 correct or clarify the previous policy noted in CR3647 (Transmittal 515 dated April 1, 2005).

The therapy code list and associated policies for CY 2006 is updated by CR4226 as described below.

CR3647 can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R515CP.pdf>

The Medlearn Matters article that corresponds to CR3647 can be reviewed on the CMS web site at:

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3647.pdf>

### Orthotic Management and Prosthetic Management Services

In order to create a new category under the section for physical medicine and rehabilitation services, HCPCS/CPT modified the descriptors of one of these codes, CPT 97504 (2005), and renumbered it as well as two other HCPCS/CPT codes.

The new therapy code list removes the CY 2005 CPT codes 97504, 97520 and 97703, and replaces them with CPT codes 97760, 97761 and 97762, respectively, for use in CY 2006. The following table contains a list of the added CY 2006 CPT codes and the new short descriptor for CPT code 97760:

| 2006 Code | 2006 Short Descriptor            | 2005 Code |
|-----------|----------------------------------|-----------|
| 97760     | Orthotic management and training | 97504     |
| 97761     | Prosthetic training              | 97520     |
| 97762     | C/o for orthotic/prosth use      | 97703     |

### Active Wound Care Management Services

The therapy code list contains five (5) HCPCS/CPT codes that represent active wound care services: CPT codes 97602, 97605, 97606, 97597 and 97598. Three of these CPT codes for wound care (97602, 97605, and 97606) were previously noted as “bundled” services for payment purposes under the MPFS and represented “always therapy” services.

For CY 2006, these three codes were changed to “sometimes therapy” services. While CPT code 97602 remains a bundled service under the MPFS, CPT codes 97605 and 97606, which represent services for negative pressure wound therapy, are now valued and active codes under the MPFS.

Except as noted below for hospitals subject to the Outpatient Prospective Payment System (OPPS), the requirements for “sometimes therapy” apply. These requirements are described in more detail in Publication 100-04, Chapter 5, Section 20, of the *Medicare Claims Processing Manual*. That manual is available on the CMS web site at:

<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

A new payment policy for hospitals paid under the OPSS is being implemented for these five wound care HCPCS/CPT codes – 97602, 97605, 97606, 97597, and 97598, and the indicator “•” is being added as a note to the code list. The indicator “•” signifies that these codes represent “sometimes therapy” services and will be paid under the OPSS when (a) the service is not performed by a therapist (i.e., under the therapy benefit); and (b) it is inappropriate to bill the service under a therapy plan of care.

Wound care provided, which meets these two requirements, should not be billed with a therapy modifier (e.g., GP, G0, or GN) or a therapy revenue code (e.g., 42X, 43X, or 44X). As for other “sometimes therapy” codes, these services are considered therapy services (i.e.; under the therapy benefit) when rendered by a therapist.

They are also considered therapy services when rendered by physicians and non-physician practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. When such services are therapy services as noted above, the appropriate therapy modifier is required.

| 2006 Status   | HCPCS/CPT Code | Short Descriptor              | 2005 Status  |
|---|----------------|-------------------------------|--|
| Bundled service for payment purposes under the MPFS; sometimes therapy service. | 97602          | Wound (s) care, non-selective | Bundled service for payment purposes under the MPFS; always therapy service. |
| Valued and active code under the MPFS; sometimes therapy service.               | 97605          | Neg press wound tx, < 50 cm   | Bundled service for payment purposes under the MPFS; always therapy service. |
| Valued and active code under the MPFS; sometimes therapy service.               | 97606          | Neg press wound tx, > 50 cm   | Bundled service for payment purposes under the MPFS; always therapy service. |
| Sometimes therapy service.  | 97597          | Active wound care/20 cm or <  | Sometimes therapy service.   |
| Sometimes therapy service.  | 97598          | Active wound care > 20 cm     | Sometimes therapy service.   |

### Carrier Pricing of Unspecified Therapy Codes

The 2006 policy adds Note “•” to HCPCS/CPT codes 97039 and 97139 to indicate that the MPFS payment has changed to carrier-pricing and these two codes will no longer be paid using the relative values units previously listed in Addendum B of the 2006 MPFS final rule.

As with other carrier-priced services, where an existing HCPCS/CPT code does not accurately describe the services performed, the provider submits information, for the contractor’s review, to describe the “unspecified” modality(s) or therapeutic procedure(s) performed.

In addition to a detailed service description for CPT code 97039, information submitted to the contractor must specify the type of modality utilized and, if the modality requires the constant attendance of the therapist, the time spent by the therapist one-on-one with the beneficiary must also be noted.

For CPT code 97139, the information supplied to the carrier must specify the procedure furnished and also meet the other requirements for therapeutic procedures, i.e., the process of effecting change, through the application of clinical skills or services that attempt to improve function.

CPT codes 97039 and 97139 remain designated as “always therapy” and require the use of the GP or GO modifier, as appropriate.

| HCPCS/CPT Code | Short Descriptor            |
|----------------|-----------------------------|
| 97039          | Physical therapy treatment  |
| 97139          | Physical medicine procedure |

### Speech, Language, Voice, Communication and/or Auditory Processing

The 2006 policy creates a “•” indicator to indicate that the CY 2006 code descriptors were revised for the following CPT codes: 92506 and 92507. CPT code 97760 is also flagged with the “•.” Although this code number is new, it reflects a revision to the descriptor of the code it replaces, CPT 97504. The revised 2006 descriptors for 95206 and 95207 are the following:

| 2006 Code | 2006 Short Descriptor     |
|-----------|---------------------------|
| 92506     | Speech/hearing evaluation |
| 92507     | Speech/hearing therapy    |

### Microwave Modality

The 2006 policy removes deleted HCPCS/CPT codes 96115 and 97020. CPT 96115 was deleted for CY 2006. CPT code 97020, for the microwave modality, was combined with CPT code 97024 for diathermy.

| 2006 Code | 2006 Short Descriptor     |
|-----------|---------------------------|
| 97024     | Diathermy e.g., microwave |

### Code 0019T

The 2006 policy adds HCPCS/CPT code 0019T, as a “sometimes” therapy service, to replace HCPCS codes G0279 and G0280 that were both deleted for CY2006. This code is carrier priced.

| 2006 Code | 2006 Short Descriptor         | 2006 Status       |
|-----------|-------------------------------|-------------------|
| 0019T     | Extracorp shock wv tx, ms nos | Sometimes therapy |

### Diagnostic Services

The 2006 policy clarifies in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 5, Section 20, Subsection C (Additional HCPCS Codes)), that the listed HCPCS/CPT codes 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904 and 95934 represent diagnostic services, under MPFS, and do not represent therapy services and cannot be billed as such. Those codes and their short descriptors are in the following table:

| HCPCS/CPT Code | Short Descriptor             | Status under MPFS  |
|----------------|------------------------------|--------------------|
| 95860          | Muscle trest, one limb       | Diagnostic Service |
| 95861          | Muscle test, 2 limbs         | Diagnostic Service |
| 95863          | Muscle test, 3 limbs         | Diagnostic Service |
| 95864          | Muscle test, 4 limbs         | Diagnostic Service |
| 95867          | Muscle test cran nerv unilat | Diagnostic Service |
| 95868          | Muscle test cran nerve bilat | Diagnostic Service |
| 95869          | Muscle test, thor paraspinal | Diagnostic Service |
| 95870          | Muscle test, nonparaspinal   | Diagnostic Service |
| 95900          | Motor nerve conduction test  | Diagnostic Service |
| 95903          | Motor nerve conduction test  | Diagnostic Service |
| 95904          | Sense nerve conduction test  | Diagnostic Service |
| 95934          | H-reflex test                | Diagnostic Service |

### Code 96110

The 2006 policy removes the “•” note for CPT code 96110, because it is no longer applicable. The “•” note indicated that, effective January 1, 2004, CPT 96110 became an active code on the physician fee schedule and that carriers no longer priced this code.

| HCPCS/CPT Code | Short Descriptor        |
|----------------|-------------------------|
| 96110          | Developmental test, lim |

***Summary***

In summary, CR4226 instructs your carrier and/or FI/RHHI to change any policies or edits that are not consistent with the policies or list of codes provided in CR 4226.

The changes noted in CR4226 are effective for services furnished on or after January 1, 2006. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2006 HCPCS/CPT-4.

***Implementation***

The implementation date for the instruction is February 6, 2006.

***Additional Information***

For complete details, please see the official instruction issued to your carrier/FI/RHHI regarding this change. That instruction may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R805CP.pdf>

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/apps/contacts/>

## Therapy Caps to Be Effective January 1, 2006

Reference: Trans. 759, CR #4115, Pub. 100-04, Medlearn Matters Number: MM4115

**Note:** This article was revised on March 3, 2006, to include clarifying language (bold, italicized print) in the section titled "Impact to You."

### *Provider Types Affected*

Therapists and providers who bill Medicare carriers or fiscal intermediaries (FIs) for therapy services for their patients

### *Impact to You*

Beginning January 1, 2006, financial limitation of therapy services (therapy caps) will be implemented. ***The dollar amount for the 2006 limitation on physical therapy and speech-language pathology services from January 1, 2006, through December 31, 2006, will be \$1,740.00 both services combined. The limitation on occupational therapy services is also \$1,740.00. The limits do not apply to outpatient Part B therapy services in outpatient hospital or hospital emergency room settings or to services that meet Medicare criteria for exceptions.***

### *What You Need to Know*

Please be aware of the January 1, 2006 therapy services caps.

### *What You Need to Do*

Remember that services must meet the Medicare policies in the Medicare Benefit Policy Manual (publication 100-02), Chapter 15, Sections 220 and 230. This manual is available on the CMS web site at:

<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

### *Background*

Financial limitations on therapy services (therapy caps) are currently described in the *Medicare Claims Processing Manual* (Pub. 100-04), chapter 5, section 10.2, which is available on the CMS web site at:

<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

The dollar amount for the limitations in 2006 is based on the Medicare Economic Index that is published in the final rule for the Medicare Physician Fee Schedule in November, 2005.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, including outpatient speech-language pathology, and occupational therapy). Section 4541(c) of the BBA required the application of a financial limitation to all outpatient rehabilitation services (except outpatient departments of hospitals).

These limits were in effect in 1999, but were removed by law in 2000-2002. The statutory limits went back into effect September 1, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 re-enacted the moratorium and extended it until December 31, 2005.

### *Additional Information*

There is additional information located on the Rehabilitation Therapy Information Resource for Medicare web site located on the CMS web site at:

[http://new.cms.hhs.gov/TherapyServices/01\\_overview.asp#TopOfPage](http://new.cms.hhs.gov/TherapyServices/01_overview.asp#TopOfPage)

The official instruction issued to your FI or carrier regarding this change may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/transmittals/downloads/R759CP.pdf>

Please refer to your local FI or carrier if you have any questions. To find the toll free phone number, go on the CMS web site to:

<http://www.cms.hhs.gov/apps/contacts/>



# Medicare Web-Based Training

**Q: How can I learn more about Medicare?**

**A: Medicare Web-Based Training!**

## Top Five Reasons You Should Utilize Web-Based Training Is:

1. **Flexible** Medicare Web-based training is available 24 hours a day, 7 days a week.
2. **Cost-effective** The training is free.
3. **Time Saver** Complete courses in the comfort of your home or office.
4. **Interactive** Utilizes a multi-sensory approach to engage the learner.
5. **In Demand** Over 95% of learners report they are very satisfied with the quality of the courses.

As your Medicare Carrier, we are constantly seeking innovative ways to keep you informed and knowledgeable regarding Medicare policies and procedures. With that in mind, we now offer web-based training to the provider community at no charge.

## Current Topics

|   |  |
|---|--|
| Ambulance   | Skilled Nursing Facility (SNF) – Medicare Part A Billing |
| Introduction to Medicare*                                 | National & Local Coverage Determinations*                |
| Modifiers*  | Wound Care*  |
| Critical Care Services*                                   | Interpreting the Remittance Advice*                      |
| Chiropractic Services*                                    | Physical Medicine and Rehabilitation*                    |
| Podiatry Services*  | Evaluation & Management Services*                        |
| Understanding the '97 Evaluation & Management Guidelines* |  |

\* Continuing Education Units (CEUs) and Continuing Medical Education (CME) credit has been approved for the courses above.

\*\* CEU/CME approval pending

For more information visit your Medicare Carrier's website:

|                     |  |
|---------------------|--|
| Arkansas            | <a href="http://www.arkmedicare.com/provider/wbt">www.arkmedicare.com/provider/wbt</a>   |
| Louisiana           | <a href="http://www.lamedicare.com/provider/wbt">www.lamedicare.com/provider/wbt</a>     |
| Missouri            | <a href="http://www.momedicare.com/provider/wbt">www.momedicare.com/provider/wbt</a>     |
| Oklahoma/New Mexico | <a href="http://www.oknmmedicare.com/provider/wbt">www.oknmmedicare.com/provider/wbt</a> |
| Rhode Island        | <a href="http://www.rimedicare.com/provider/wbt">www.rimedicare.com/provider/wbt</a>     |



## Pinnacle Medicare Services Seminar Registration

Registering for Medicare seminars just became easier. You can register online or, you can use this form to register by mail for Medicare seminars presented by each office within the Pinnacle consortium. Please complete all of the requested information and mail the form to the address indicated below for your state:

| <b>Arkansas</b><br><i>www.arkmedicare.com</i>   | <b>Louisiana</b><br><i>www.lamedicare.com</i>  | <b>Missouri</b><br><i>www.momedicare.com</i>  | <b>Oklahoma/New Mexico</b><br><i>www.oknmmedicare.com</i>  | <b>Rhode Island</b><br><i>www.rimedicare.com</i>   |
|---|--|---|--|--|
| Pinnacle Medicare Part B<br>Attn: Provider Education Specialist<br>P.O. Box 1418<br>Little Rock, AR<br>72203-1418 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 83760<br>Baton Rouge, LA<br>70884-3760 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 1418<br>Little Rock, AR<br>72203-1418 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 83760<br>Baton Rouge, LA<br>70884-3760 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 249<br>Providence, RI<br>02901 |

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Seminar Number: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_

Number of attendees: \_\_\_\_\_ x \$30.00 per person = \$ \_\_\_\_\_ Total Amount Enclosed  
(fees for seminars/workshops are non-refundable)

Make checks or money orders payable to *Pinnacle Medicare Services*. We cannot accept cash or credit cards. Also note, for accounting purposes, we request that you submit payment for seminars/workshops separate from overpayment refunds.

Attendee Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How many physicians/practitioners are the above attendees representing?:** \_\_\_\_\_

Office/Physician's Name: \_\_\_\_\_

Contact Name(s): \_\_\_\_\_ Provider Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Please keep a copy of this form for your records**

## Have a Question?

Your questions are important to us! In our continuing effort to expand the communication between Medicare and the Part B providers, we have established an "And The Answer Is....." column for our providers. If you have a question about Medicare Part B policies and regulations, you may use the form shown below. We will print the most commonly asked questions with their answers. Questions not printed in the newsletter will be addressed through written or telephone response, so be sure to include your name, address and telephone number.

### ***"Did You Know?" Question Submission Form***

Provider/Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Provider Number: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Telephone Number:( \_\_\_\_\_ ) \_\_\_\_\_

Question: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Question submission forms should be sent to:

Pinnacle Medicare Communications  
12755 Olive Blvd.; Suite 105  
Creve Coeur, MO 63141

## Your Feedback is Greatly Appreciated!

We would like to take this opportunity to ask you for your input about our service to you and how you think we can improve. Please take a few moments to answer the questions below. Your response will help us serve you better in the future. All comments, concerns and suggestions are welcome.

We suggest you make a copy of this form so that you may use it after any contact with our office (good or bad) on which you would like to comment. After completing the form, mail it to the Pinnacle Medicare Service office you had contact with. Here are the addresses to mail this form:

### Arkansas

Pinnacle Medicare Services  
Attn: Greg Hart  
P.O. Box 1418  
Little Rock, AR 72203

### Louisiana

Pinnacle Medicare Services  
Attention: Kim Gassie  
P.O. Box 83760  
Baton Rouge, LA 70884

### Missouri

Pinnacle Medicare Services  
Attention: Greg Hart  
P.O. Box 1418  
Little Rock, AR 72203

### New Mexico

Pinnacle Medicare Services  
Attention: Kim Gassie  
P.O. Box 83760  
Baton Rouge, LA 70884

### Oklahoma

Pinnacle Medicare Services  
Attention: Kim Gassie  
P.O. Box 83760  
Baton Rouge, LA 70884

### Rhode Island

Pinnacle Medicare Services  
Attention: Greg Hart  
P.O. Box 1418  
Little Rock, AR 72203

### Medicare Program:

Every day our staff makes numerous contacts with the provider community. Please comment on any contact you have had with our office that you would like us to know about. We appreciate being notified of any contact with an employee that meets your standard of excellence or any employee that falls below that standard.

Date of contact: \_\_\_\_\_ Contact was made: In person \_\_\_\_\_ By telephone \_\_\_\_\_

Name of Pinnacle employee that assisted you: \_\_\_\_\_  
(Employees should answer with their name.)

Provide us with a general description of the topic discussed or question(s) you asked.

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Was our response clear and easy to understand? \_\_\_\_\_

Was our staff member friendly and helpful? (If not, what happened?) \_\_\_\_\_

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General comments: \_\_\_\_\_

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### Interactive Voice Response Unit:

Do you use the IVR regularly? (If not, why not?) \_\_\_\_\_

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Do you find the IVR to be an effective tool for you and your staff? (Why or why not?)

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What features do you feel you and your staff would use which are not available?  
(Please remember, we cannot verify entitlement or deductible status through the IVR.)

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*(continued on next page)*

**Seminars:**

Medicare seminars are designed to meet your needs. How can we improve our service to you?

\_\_\_\_\_ More frequent          \_\_\_\_\_ Longer seminars          \_\_\_\_\_ Specialty workshops

If you desire a specialty workshop, please indicate your specialty **and** topics to be addressed.

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**Website:**

Have you ever visited our website?          \_\_\_\_\_ Yes          \_\_\_\_\_ No

If yes, how often do you visit our website? \_\_\_\_\_

Do you find the website easy to navigate?          \_\_\_\_\_ Yes          \_\_\_\_\_ No

Our websites are for your benefit. Please indicate suggestions/improvements below:

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Thank you for your time and cooperation in responding to these questions. We value your input and constructive suggestions to help us better serve the medical community. Mail all completed forms to the carrier that services your state. Please do not forget to give us your name and telephone number.

\_\_\_\_\_ (      ) \_\_\_\_\_  
Name Telephone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip Code

Pinnacle Medicare Services offers an electronic manual that contains important information to help you submit Part B claims correctly.



The manual, available on CD-Rom and the Internet contains:

- All Pinnacle Medicare Services policies
- Coverage guidelines by specialty (i.e., ambulance, chiropractors, pathology, ophthalmology, psychiatry, etc.)
- Billing instructions
- Information about becoming a Medicare provider

The manual includes general information about billing Medicare Part B as well as state specific policies and specific information for billing the Medicare Part B carrier in your state. The price for MedGuide is:

- \$100.00 for the CD-Rom (single user)
- Free on the Internet (on your state's website)

The fee for the CD-Rom version includes updates three times a year for the calendar year in which MedGuide was purchased. In February of each subsequent year, we will issue an invoice for renewal of your MedGuide update subscription.

To obtain your copy of MedGuide, please complete the information below and return this form with a check for the appropriate amount. Make checks payable to Medicare Services.

Name: \_\_\_\_\_

Attn: \_\_\_\_\_

Provider Number (if applicable): \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address (include zip): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Circle the state(s) for which you require a manual: AR LA MO NM/OK RI

If you have any questions, please call (314) 317-2732

Please return this form and payment (checks payable to Medicare Services) to:

PINNACLE MEDICARE SERVICES

Attn: Scott Thier

12755 Olive Blvd., Suite 105

Creve Coeur, MO 63141



## Arkansas Information

This information only applies to Medicare Part B providers in Arkansas. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 345-0274.

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### Probe Review Results of Subsequent Nursing Facility Care Evaluation and Management Code 99311 in Arkansas

Reference: AR- KLB 030706

A widespread pre-pay probe review was performed for Subsequent Nursing Facility (SNF) care evaluation and management (E/M) services in Arkansas, for CPT code 99311. The following criteria were utilized:

- Provider Specialty: 08
- Place of Service: 31 and 32 (Nursing Facilities)
- Procedure Code: CPT 99311 – *Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making of straightforward or low complexity. Usually, the patient is stable, recovering, or improving.*  
CPT 2005 © 2004, AMA
- Diagnosis Code(s): Varied
- Dates of Services Billed: March 9, 2005 through October 19, 2005

#### **Rationale for Review:**

- Carrier data showed widespread utilization of SNF evaluation and management codes across multiple specialties.
- SNF evaluation and management services represented 2.4% of total Comprehensive Error Rate Testing (CERT) errors for the Arkansas Medicare Coverage Area for the time period December 2004 through April 2005. Service incorrectly coded accounted for 55.6% of the errors, insufficient documentation accounted for 22.2% of the errors, and no documentation accounted for 22.2% of the errors.
- To ensure that providers are knowledgeable of coverage, coding, and billing requirements, both widespread and provider specific probe reviews will be performed in FY 2006 to identify appropriate educational opportunities.

#### **Probe Results for CPT 99311:**

A total of 101 claims, 131 services, for CPT code 99311, were randomly selected for prepay review. Of the 131 services reviewed:

- 109 were supported as billed.
- Twenty-two (22) were denied for the following reasons:
  - Ø Two (2) services were denied as not medically necessary because the provider did not meet at least two of the required components of this code.
  - Ø Nine (9) services were denied as no response to the request for additional documentation (ADR).
  - Ø Eleven (11) services were denied as insufficient documentation due to documentation for the dates of service was missing or incomplete, documentation was illegible, or not signed by the billing provider.

#### **Issues Identified from Probe:**

- The provider made no response to Medical Review's request for additional documentation.
- The services were denied due to lack of documentation of two of the three required components of the code.
- Insufficient documentation was submitted; records for the particular date of service needed were missing.
- The documentation presented was illegible.
- No signature of the performing provider on the documentation.
- Some documentation reflected a higher level of evaluation and management than was billed.

#### **Recommendations for Providers:**

- Review the 1995/1997 Evaluation and Management Guidelines, which may be found at [www.cms.hhs.gov/MedlearnProducts/20\\_DocGuide.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/20_DocGuide.asp#TopOfPage)
- Send documentation for future requests within the 30 day time-frame.



## Arkansas Information

*This information only applies to Medicare Part B providers in Arkansas. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 345-0274.*

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- Ø Title XVIII of the Social Security Act, Section 1862 (a)(1)(A) prohibits Medicare payment for any claim which lacks the necessary information to process the claim; therefore no response to our request for medical records will result in denial of your claims.
- Please review the article in the May 2004 Medicare Provider News entitled “Coding of Subsequent Hospital Care,” which may be of assistance in utilizing these codes. This article applies to all E/M codes, not just subsequent hospital care codes.
  - Please review Medicare Change Request 2321, which states, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.”
  - When the condition of the patient warrants more extensive documentation and decision making that that required for the level of service billed, it would be appropriate to bill the higher level of service.
  - Documentation submitted must include the specific services and dates requested for the billing provider.
  - Legible documentation is a requirement. Documentation that is poorly legible has a direct affect on the reviewer’s ability to make a fair determination and on the overall review process.
  - Payment is made for visits required to monitor and evaluate residents at least once every thirty days for the first ninety days after admission and at least once every sixty days thereafter. Medicare does not pay for additional visits that may be required by state law for an admission or other purposes, unless the visits are necessary to meet the medical needs of the individual resident.
  - Please note that Subsequent Nursing Facility Care codes have changed in the 2006 CPT to 99307 – 99310. CPT code 99311 has been changed to CPT 99307 and the level of decision making has changed from straightforward or low complexity to straightforward complexity.

### References:

- 1995/1997 Documentation Guidelines for Evaluation and Management Services
- Current Procedural Terminology, CPT 2005, Professional Edition © 2004, AMA
- Medicare Provider News, May 2004, “Coding of Subsequent Hospital Care”
- Medicare Change Request (CR) 2321, which may be found at <http://www.cms.hhs.gov/Transmittals/2004Trans/List.asp#TopOfPage> and Medicare Claims Processing Manual, Chapter 12, section 30.6.1

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## Patient Choice Guaranteed

*Reference: AR - RTH 032106*

AdvanceMed, the Program Safeguard Contractor for the state of Arkansas, has recently become aware that discharge planners in some facilities limit a beneficiary’s choice of skilled nursing, home health, etc., in their efforts to steer patients toward providers with whom the facility has a financial relationship. Please be advised that this is inappropriate and against federal law.

Sec. 1802. [42 U.S.C. 1395a] of the Social Security Act seeks to ensure that free choice is guaranteed to all Medicare patients:

*(a) Basic freedom of choice —Any individual entitled to insurance benefits [i.e., Medicare] under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.*

Further, Sec. 1861(ee)(2) of the Act, defines discharge planning as including an evaluation of need and availability of services through individuals and entities that participate in the program and that serve the area in which the patient resides, and requires facilities to disclose any identified providers with whom the facility has a financial relationship. (Note that instructions differ for Medicare + Choice.)

In accordance with Medicare guidelines, please ensure that discharge-planning procedures in your facility respect the Medicare beneficiary’s right to choice.



## Louisiana Information

This information only applies to Medicare Part B providers in Louisiana. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 567-8419.

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# Probe Review Results of Subsequent Nursing Facility Care Evaluation and Management Code 99312 in Louisiana

Reference: AR - HDM 030906

A widespread pre-pay probe review was performed for Subsequent Nursing Facility (SNF) care evaluation and management (E/M) services in Louisiana, for CPT code 99312. The following criteria were utilized:

- Provider Specialties: 29 (Pulmonary Disease), 39 (Nephrology), 44 (Infectious Disease), and 46 (Endocrinology)
- Place of Service: 21 – Inpatient Hospital
- Procedure Code: CPT 99312 – *Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.* CPT 2005 © 2004, AMA
- Diagnosis Code(s): Varied
- Dates of Services Billed: April 29, 2005 through November 12, 2005

### **Rationale for Review:**

- Carrier data showed widespread utilization of SNF evaluation and management codes across multiple specialties. Two provider specific probes were performed in FY 2005 in each of the six states of the Arkansas Medicare Coverage Area for codes 99311 - 99313. In Louisiana, these indicated an error rate by services of 10% and 60%.
- SNF evaluation and management services represented 2.4% of total Comprehensive Error Rate Testing (CERT) errors for the Arkansas Medicare Coverage Area for the time period December 2004 through April 2005. Service incorrectly coded accounted for 55.6% of the errors, insufficient documentation accounted for 22.2% of the errors, and no documentation accounted for 22.2% of the errors.
- To ensure that providers are knowledgeable of coverage, coding, and billing requirements, both widespread and provider specific probe reviews will be performed in FY 2006 to identify appropriate educational opportunities.

### **Probe Results for CPT 99312:**

A total of 103 claims, 154 services, for CPT code 99312, were randomly selected for prepay review, with no more than ten claims from any one provider. Of the 154 services reviewed:

- Forty-one (41) were supported as billed.
- 113 were denied for the following reasons:
  - Ø Twenty-two (22) services were down-coded to 99231 because the level of decision making did not support this higher level of service.
  - Ø Fifty-five (55) services were denied as no response to the request for additional documentation (ADR).
  - Ø Thirty-six (36) services were denied as insufficient documentation due to documentation for the dates of service was missing or incomplete.

Services were allowed if documentation supported that the patient was being seen for a monthly (30) day evaluation or that there was a problem being managed and documentation met the minimal criteria for this level of service.

### **Issues Identified from Probe:**

- The provider made no response to Medical Review's request for additional documentation.
- Services were re-coded to a lesser level of service for the following reasons:
  - Ø The level of decision making did not support the level of service billed (whether or not history and/or exam met minimal criteria for the level of service billed).
  - Ø The level of decision making supported the level of service billed, but the documentation of history and exam did not meet minimal criteria for this level of service.



## **Louisiana Information**

*This information only applies to Medicare Part B providers in Louisiana. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 567-8419.*

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- Documentation did not support the medical necessity of the service for the following reasons:
  - Ø There was no problem or treatment that required the services of this specialty.
  - Ø The level of decision making did not support the level of service billed, causing the service billed to be paid at a lesser level of service.
- Insufficient documentation was submitted; records for the particular date of service needed were missing.

### **Recommendations for Providers:**

- Review the 1995/1997 Evaluation and Management Guidelines, which may be found at [www.cms.hhs.gov/MedlearnProducts/20\\_DocGuide.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/20_DocGuide.asp#TopOfPage)
- Send documentation for future requests within the 30 day time-frame.
  - Ø Title XVIII of the Social Security Act, Section 1862 (a)(1)(A) prohibits Medicare payment for any claim which lacks the necessary information to process the claim; therefore no response to our request for medical records will result in denial of your claims.
- Documentation of history, physical examinations, and medical decision making should not be billed at levels greater than needed for the patient's condition.
- Please review the article in the May 2004 *Medicare Provider News* entitled "Coding of Subsequent Hospital Care," which may be of assistance in utilizing these codes. This article applies to all E/M codes, not just subsequent hospital care codes.
- Please review Medicare Change Request 2321, which states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."
- When the condition of the patient warrants more extensive documentation and decision making than that required for the level of service billed, it would be appropriate to bill the higher level of service.
- If the patient is being seen for initial admission or readmission to the facility, it would be appropriate to document and bill for the appropriate comprehensive service rather than a subsequent nursing facility service.
- Documentation submitted must include the specific services and dates requested for the billing provider.
- Legible documentation is a requirement. Documentation that is poorly legible has a direct affect on the reviewer's ability to make a fair determination and on the overall review process.
- Payment is made for visits required to monitor and evaluate residents at least once every thirty days for the first ninety days after admission and at least once every sixty days thereafter. Medicare does not pay for additional visits that may be required by state law for an admission or other purposes, unless the visits are necessary to meet the medical needs of the individual resident.
- Please note that Subsequent Nursing Facility Care codes have changed in the 2006 CPT to 99307 – 99310. CPT code 99312 has been changed to CPT 99308 and the level of decision making has changed from moderate to low complexity.

### **References:**

- 1995/1997 Documentation Guidelines for Evaluation and Management Services
- Current Procedural Terminology, CPT 2005, Professional Edition © 2004, AMA
- *Medicare Provider News*, May 2004, "Coding of Subsequent Hospital Care"
- Medicare Change Request (CR) 2321, which may be found at <http://www.cms.hhs.gov/Transmittals/2004Trans/List.asp#TopOfPage>



## **Louisiana Information**

*This information only applies to Medicare Part B providers in Louisiana. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 567-8419.*

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### **Patient Choice Guaranteed**

*Reference: AR - RTH 032106*

AdvanceMed, the Program Safeguard Contractor for the state of Louisiana, has recently become aware that discharge planners in some facilities limit a beneficiary's choice of skilled nursing, home health, etc., in their efforts to steer patients toward providers with whom the facility has a financial relationship. Please be advised that this is inappropriate and against federal law.

Sec. 1802. [42 U.S.C. 1395a] of the Social Security Act seeks to ensure that free choice is guaranteed to all Medicare patients:

*(a) Basic freedom of choice —Any individual entitled to insurance benefits [i.e., Medicare] under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.*

Further, Sec. 1861(ee)(2) of the Act, defines discharge planning as including an evaluation of need and availability of services through individuals and entities that participate in the program and that serve the area in which the patient resides, and requires facilities to disclose any identified providers with whom the facility has a financial relationship. (Note that instructions differ for Medicare + Choice.)

In accordance with Medicare guidelines, please ensure that discharge-planning procedures in your facility respect the Medicare beneficiary's right to choice.



**Missouri Information**

*This information only applies to Medicare Part B providers in Missouri. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 736-0799.*

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**THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME**



## Oklahoma/New Mexico Information

This information only applies to Medicare Part B providers in Oklahoma and New Mexico. If you have any questions regarding the information in this section, please call (877) 280-6520.

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### Probe Review Results of Initial Hospital Care Evaluation and Management Code 99222 in Oklahoma

Reference: AR - KLB 030906

A widespread pre-pay probe review was performed for initial hospital care evaluation and management (E/M) services in Oklahoma, for CPT® code 99222. The following criteria were utilized:

- Provider Specialties: 01 (General Practice) and 08 (Family Practice)
- Place of Service: 21 – Inpatient Hospital
- Procedure Code: CPT 99222 – *Initial Hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity.* Current Procedural Terminology © 2005 American Medical Association. All Rights Reserved.
- Diagnosis Code(s): Varied
- Dates of Services Billed: March 31, 2004 through November 10, 2005

#### **Rationale for Review:**

- Initial Hospital evaluation and management services represented 4.6% of the total Comprehensive Error Rate Testing (CERT) errors for the Arkansas Medicare Coverage Area for the time period December 2004 through April 2005. Service incorrectly coded accounted for 70.6% of the errors and insufficient documentation accounted for 29.4% of the errors.
- In Oklahoma, Specialty 01 and 08 were identified by Medical Review Data Analysis as outliers in distribution analysis.
- Data showed that specialty 01 exceeds the nation in allowed services for CPT code 99222 and 99223 for the time period of July-December 2004.

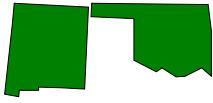
#### **Probe Results for CPT 99222:**

A total of 100 claims, 100 services, for CPT code 99222, were randomly selected for prepay review. Of the 100 services reviewed:

- Thirty-two (32) were denied for records not received within the required time frame.
- Twenty-one (21) services were denied as insufficient documentation.
- Seven (7) were recoded to another procedure code.
- Two (2) were denied as services not performed.

#### **Issues Identified from Probe:**

- The provider made no response to Medical Review's request for additional documentation.
- Incomplete documentation of a comprehensive history, which requires the following:
  - Ø A chief complaint
  - Ø History of present illness with at least 4 elements or the status of three chronic conditions
  - Ø Complete review of systems
  - Ø Complete past, family, and social history.
- Insufficient Documentation of the Examination
  - Ø CPT code 99222 requires a comprehensive examination, for some services, the exam was detailed, resulting in re-coding of the service.
  - Ø Abnormal or negative findings require elaboration; notation of "negative" or "abnormal" is insufficient to satisfy the requirement.
- Insufficient documentation of Decision Making
  - Ø No documentation of treatment plan or orders for the date of service, which would be required to meet the criteria of medical decision making.
  - Ø Documentation for a date span without documentation for each date billed.
  - Ø The documentation did not support moderate medical decision making.



## Oklahoma/New Mexico Information

*This information only applies to Medicare Part B providers in Oklahoma and New Mexico. If you have any questions regarding the information in this section, please call (877) 280-6520.*

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- Several records had multiple providers listed with no signature to indicate who performed the service.
- Billing provider was different than the performing provider.
- Illegible documentation

### **Recommendations for Providers:**

- Review the 1995/1997 Evaluation and Management Guidelines, which may be found at [www.cms.hhs.gov/MedlearnProducts/20\\_DocGuide.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/20_DocGuide.asp#TopOfPage)
- Send documentation for future requests within the 30 day time-frame.
  - Ø Title XVIII of the Social Security Act, Section 1862 (a)(1)(A) prohibits Medicare payment for any claim which lacks the necessary information to process the claim; therefore no response to our request for medical records will result in denial of your claims.
- Documentation of history, physical examinations, and medical decision making should not be billed at levels greater than needed for the patient's condition.
- Please review the article in the May 2004 *Medicare Provider News* entitled "Coding of Subsequent Hospital Care," which may be of assistance in utilizing these codes. This article applies to all E/M codes, not just subsequent hospital care codes.
- Documentation submitted must include the specific services and dates requested for the billing provider.
- Legible documentation is a requirement. Documentation that is poorly legible has a direct affect on the reviewer's ability to make a fair determination and on the overall review process.

### **References:**

- 1995/1997 Documentation Guidelines for Evaluation and Management Services
- Current Procedural Terminology, CPT 2005, Professional Edition © 2004, AMA
- *Medicare Provider News*, May 2004, "Coding of Subsequent Hospital Care"

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## Patient Choice Guaranteed

*Reference: AR - RTH 032106*

AdvanceMed, the Program Safeguard Contractor for the state of Oklahoma, has recently become aware that discharge planners in some facilities limit a beneficiary's choice of skilled nursing, home health, etc., in their efforts to steer patients toward providers with whom the facility has a financial relationship. Please be advised that this is inappropriate and against federal law.

Sec. 1802. [42 U.S.C. 1395a] of the Social Security Act seeks to ensure that free choice is guaranteed to all Medicare patients:

*(a) Basic freedom of choice —Any individual entitled to insurance benefits [i.e., Medicare] under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.*

Further, Sec. 1861(ee)(2) of the Act, defines discharge planning as including an evaluation of need and availability of services through individuals and entities that participate in the program and that serve the area in which the patient resides, and requires facilities to disclose any identified providers with whom the facility has a financial relationship. (Note that instructions differ for Medicare + Choice.)

In accordance with Medicare guidelines, please ensure that discharge-planning procedures in your facility respect the Medicare beneficiary's right to choice.



## **Rhode Island Information**

*This information only applies to Medicare Part B providers in Rhode Island. If you have any questions regarding the information in this section, please call (866) 801-5304.*

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### **Utilization of 90862 in Rhode Island by Specialty 26**

Reference: AR - KLB 030906

Carrier data reveals that specialty 26 in Rhode Island exceeds the nation by 1.89 times in allowed services for CPT® code 90862, during the time period of January through June 2005. A review of the medical records revealed that the documentation did not support billing of 90862. The following information is provided to assist providers with appropriate billing of code 90862.

CPT code 90862 is defined as *Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.* Current Procedural Terminology © 2005 American Medical Association. All Rights Reserved.

The Local Coverage Determination (LCD) titled “Psychiatry/Psychology Services,” AC-05-002, states the following:

*“Code 90862 is not intended to refer to a brief evaluation of the patient's state or simple dosage adjustment of long-term medication. The code refers to the in-depth management of psychopharmacologic agents which are potent medications with frequent serious side effects, and represents a very skilled aspect of patient care.”*

*“HCPCS code M0064 should be used for the lesser level of drug monitoring such as simple dosage adjustment. M0064 is defined as a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.” Health Care Procedure Coding System © 2005 Practice Management Information Corporation, All Rights Reserved*

*“Codes 90862 and M0064 describe a physician service and cannot be billed by a non-physician or “incident to” a physician's service, with the exception of advanced practice nurses whose scope of license permits them to prescribe, may use M0064 if they perform follow-up services.”*

The LCD can be found on the Rhode Island Medicare website at [www.rimedicare.com](http://www.rimedicare.com) in the provider section, under medical policies.

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## **Rhode Island Information**

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### **Probe Review Results of Initial Hospital Care Evaluation and Management Code 99222 in Rhode Island**

Reference: AR - KLB 030906

A widespread pre-pay probe review was performed for initial hospital care evaluation and management (E/M) services in Rhode Island, for CPT<sup>®</sup> code 99222. The following criteria were utilized:

- Provider Specialties: 11 (Internal Medicine) and 26 (Psychiatry)
- Place of Service: 21 – Inpatient Hospital, 51-Inpatient Psychiatric Facility, 52-Psychiatric Facility-Partial Hospitalization
- Procedure Code: CPT 99222 – *Initial Hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity.* Current Procedural Terminology © 2005 American Medical Association. All Rights Reserved.
- Diagnosis Code(s): Varied
- Dates of Services Billed: January 13, 2004 through November 13, 2005

#### **Rationale for Review:**

- Initial Hospital evaluation and management services represented 4.6% of total Comprehensive Error Rate Testing (CERT) errors for the Arkansas Medicare Coverage Area for the time period December 2004 through April 2005. Service incorrectly coded accounted for 70.6% of the errors and insufficient documentation accounted for 29.4% of the errors.
- In Rhode Island, Specialty 11 and 26 were identified by Medical Review Data Analysis as outliers in distribution analysis.
- Data showed that specialty 26 exceeds the nation in allowed services for CPT code 99222 for the time period of July-December 2004.

#### **Probe Results for CPT 99222:**

A total of 102 claims, 103 services, for CPT code 99222, were randomly selected for prepay review, with no more than 8 claims from any one provider. Of the 103 services reviewed:

- Fourteen (14) services were allowed as billed.
- Thirty-seven (37) were denied for records not received within the required time frame.
- Thirty-five (35) services were down-coded to a lesser Evaluation and Management service.
- Twelve (12) services were denied as insufficient documentation.
- Five (5) services were up-coded to 99223.

#### **Issues Identified from Probe:**

- The provider made no response to Medical Review's request for additional documentation.
- Documentation failed to meet criteria for an initial care service; these services were down-coded to a subsequent hospital care level of service.
- History & Physical not included.
- Documentation represented a teaching physician service, but claims were not filed with GC modifier. The documentation was vague as to the participation of the attending provider and/or the identity of the resident/intern. Only the documentation performed by the billing provider can be reviewed for medical necessity, and did not meet the minimal criteria to support medical necessity of the service billed.
- Services billed with the GC modifier, but documentation did not include the resident/intern documentation, or the documentation was incomplete or unidentifiable.
- Subsequent Care services billed as Initial Hospital Care in error.
- The documentation did not support the level of decision making for the service billed.
- Lack of documentation to support the three required components.



## **Rhode Island Information**

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- No documentation for the provider of billed service.
- The documentation did not contain the signature of the billing provider or the signature was illegible.
- Provider's documentation supported a higher level of service than was billed.
- A service billed as initial inpatient, but the documentation supported a consultation.
- Review of systems was insufficient to meet the minimal criteria for a comprehensive history.
- Illegible documentation

### **Recommendations for Providers:**

- Review the 1995/1997 Evaluation and Management Guidelines, which may be found at [www.cms.hhs.gov/MedlearnProducts/20\\_DocGuide.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/20_DocGuide.asp#TopOfPage)
- Review 2005 CPT Manual
- Send documentation for future requests within the 30 day time-frame.
  - Ø Title XVIII of the Social Security Act, Section 1862 (a)(1)(A) prohibits Medicare payment for any claim which lacks the necessary information to process the claim; therefore no response to our request for medical records will result in denial of your claims.
- Documentation of history, physical examinations, and medical decision making should not be billed at levels greater than needed for the patient's condition.
- Please review the article in the May 2004 *Medicare Provider News* entitled "Coding of Subsequent Hospital Care," which may be of assistance in utilizing these codes. This article applies to all E/M codes, not just subsequent hospital care codes.
- Please review Medicare Change Request 2321, which states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."
- Documentation submitted must include the specific services and dates requested for the billing provider.
- Legible documentation is a requirement. Documentation that is poorly legible has a direct affect on the reviewer's ability to make a fair determination and on the overall review process.
- Review proper use of GC modifier and documentation criteria for teaching physician services.

### **References:**

- 1995/1997 Documentation Guidelines for Evaluation and Management Services
- Current Procedural Terminology, CPT 2005, Professional Edition © 2004, AMA
- *Medicare Provider News*, May 2004, "Coding of Subsequent Hospital Care"
- Medicare Change Request (CR) 2321, which may be found at <http://www.cms.hhs.gov/Transmittals/2004Trans/List.asp#TopOfPage>

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**Important Information from Your Medicare Part B Carrier**

**This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Additional copies of this and all newsletters are available at no cost from your state’s web site listed below.** Remember that this newsletter, as well as all other Medicare publications, serves as your official notice of Medicare coverage and billing information. Here is a list of phone numbers to call with questions about the information included in this newsletter. You must call the Customer Service area in the state where you are a Medicare provider. Be sure to check our web sites for the most up-to-date information:

- Arkansas ..... (866) 345-0274 ..... [www.arkmedicare.com](http://www.arkmedicare.com)
- Louisiana ..... (866) 567-8419 ..... [www.lamedicare.com](http://www.lamedicare.com)
- Missouri..... (866) 736-0799 ..... [www.momedicare.com](http://www.momedicare.com)
- Oklahoma ..... (866) 280-6520 ..... [www.oknmmedicare.com](http://www.oknmmedicare.com)
- New Mexico..... (866) 280-6520 ..... [www.oknmmedicare.com](http://www.oknmmedicare.com)
- Rhode Island..... (866) 801-5304 ..... [www.rimedicare.com](http://www.rimedicare.com)

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*Medicare Provider News*, together with occasional “*Bulletins*” and “*Policy Notices*,” serves as legal notice to providers concerning responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines.

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