



Pinnacle Medicare Providers' News

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



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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:

- Ø All Pinnacle Medicare Services policies
- Ø Coverage guidelines by specialty (i.e., ambulance, chiropractors, pathology, ophthalmology, psychiatry, etc.)
- Ø Billing instructions
- Ø 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:

- Ø \$100.00 for the CD-ROM (single user)
- Ø 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 Pinnacle 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**

Ambulatory Surgical Center (ASC)

Additional \$50 Payment for New Technology Intraocular Lenses (NTIOLs) Furnished in Ambulatory Surgical Centers (ASCs)

Reference: Trans. 914, CR #4361, Pub. 100-04, Medlearn Matters Number: MM4361

Note: This article was revised on May 4, 2006, to correct the citation to the SSA law applicable to this change. Also, language was added to show that any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period.

Provider Types Affected

Approved Ambulatory Surgical Centers (ASC) that bill Medicare for the insertion of new technology intraocular lenses (NTIOLs)

Impact to You

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay you an additional \$50 for NTIOLs that the Centers for Medicare & Medicaid Services (CMS) recognizes as Category 3 (Reduced Spherical Aberration).

What You Need to Know

Your carrier will pay you an additional \$50 for the insertion of NTIOL Category 3; Advanced Medical Optics (AMO) Tecnis® IOL, model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). In addition, any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period. Effective for all NTIOL Category 3 claims with dates of service on and after February 27, 2006, through February 26, 2011, Medicare-approved ASCs are eligible for the additional \$50 when billed using HCPCS code Q1003 along with procedure codes 66982, 66983, 66984, 66985, or 66986.

What You Need to Do

Make sure that your billing staffs are aware of this additional NTIOL payment and the required Health Care Common Procedure Coding System (HCPCS) code Q1003.

Background

Section 141(b) of the Social Security Act Amendments of 1994 (SSAA 1994) requires that CMS establish a process for designating particular intraocular lenses (IOLs) as “new technology,” and therefore eligible for additional payment. A final rule, published in the Federal Register (FR) on June 16, 1999 (64 FR 32198), established: (1) the process for adjusting payment amounts for NTIOLs that ASCs furnish; (2) an initial flat rate payment adjustment of \$50; and, (3) a 5-year payment adjustment period beginning when CMS recognizes the first of a new IOL subset or class.

CR4361, from which this article is taken, announces the approval of NTIOL Category 3 (as defined in FR 71 FR 4586, dated January 27, 2006), which applies to Advanced Medical Optics (AMO), Tecnis® IOL model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). Additionally, any subsequent IOLs having the same characteristics as the first IOL recognized for payment will receive the same adjustment for the remainder of the 5-year period. This category and the associated \$50 NTIOL Medicare payment adjustment will expire on February 26, 2011.

The payment adjustment is allowed when Medicare-approved ASCs (place of service 24) insert a Category 3 NTIOLs and submit HCPCS code Q1003 (created for this purpose) on the same claim as the surgical insertion procedure (66982, 66983, 66984, 66985, or 66986). HCPCS code Q1003 is already established and listed in the HCPCS file, and the Medicare Claims Processing Manual, chapter 14, Sections 10.2 & 40.3, have been updated to reflect this change.

Additional Information

Please be aware that carriers will deny payment for Q1003 when submitted by ASCs not approved by Medicare. If denied, the carrier will use MSN 16.2 (This service cannot be paid when provided in this location/facility) and

Claims Adjustment Reason Code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service).

Carriers will return as unprocessable claims for NTIOLs with Q1003 alone or with a procedure code other than 66982, 66983, 66984, 66985, or 66986. When such claims are returned, use claim adjustment reason code 16 (Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice codes whenever appropriate), remittance advice remark code of M67 (Missing/Incomplete/Invalid other procedure codes) and remark code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information).

Further, they will deny payment if submitted for services rendered after the discontinued date (February 26, 2011). If denied, they will use MSN 21.11 (This service was not covered by Medicare at the time you received it) and Claims Adjustment Reason Code 27 (Expenses incurred after coverage terminated).

Lastly, contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention with dates of service on and after February 27, 2006.

You can find more information about approval of the \$50 additional payment for NTIOL Category 3 by reviewing CR4361, which is available on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R914CP.pdf>

The revised *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.2 (10.2 - Ambulatory Surgical Center Services on ASC List) and 40.3 – (Payment for Intraocular Lens (IOL)) are attached to CR4361.

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

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

Ambulatory Surgical Center (ASC) Claims Processing Manual Clarification

Reference: Trans. 942, CR #5026, Pub. 100-04, Medlearn Matters Number: MM5026

Provider Types Affected

Providers and suppliers of ambulatory surgical center (ASC) services

Provider Action Needed

This article is for informational purposes. CR5026 revises the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) to clarify policy regarding the provision, coverage, and payment of services furnished in an ASC.

Background

Medicare conventionally reimburses ASCs in the form of a single payment that includes all “facility services” that the ASC furnishes in connection with a covered procedure. However, an ASC (perhaps as part of a medical complex that may include other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician’s office) may also furnish a number of covered items and services that are not considered facility services.

You should be aware that such entities, which are separate from the ASC, are covered separately under Part B. Further, in general, the items or services that these entities provide are not considered ASC services, and are therefore not included in the ASC payment, but are rather covered and paid for under the applicable Part B provisions.

Examples of such services include:

- Ø Physicians’ services;
- Ø Durable medical equipment (DME);
- Ø Implantable DME;
- Ø Prosthetic devices;
- Ø Ambulance services;
- Ø Leg, arm, back and neck braces;
- Ø Artificial legs, arms and eyes; and
- Ø Services of an independent laboratory.

More detail about each of these services can be seen in Table 1, below.

Table 1
Examples of Services Not Included in the ASC Facility Rate

Items or Services	Who Receives Payment	Submit Bills To
<p>Physicians’ services</p> <p>Physicians who perform covered services in ASCs receive separate payment under Part B. Such services include:</p> <p>Anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients’ recovery from the anesthesia;</p> <p>Routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, suture removal, dressing changes, and other services which are usually included in the physician fee for a given surgical procedure.</p>	Physician	Carrier

Items or Services	Who Receives Payment	Submit Bills To
<p>Non-implantable durable medical equipment (DME) to ASC patients for in-home use</p> <p>ASCs who sell, lease, or rent items of DME to patients, are treated as DME suppliers.</p> <p>All of the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p> <p>An ASC can be a supplier of DME if it has a DME supplier number from the National Supplier Clearinghouse.</p>	<p>DMERC</p>
<p>Implantable DME and accessories</p> <p>ASCs who furnish implantable DME items to patients, bill the local carrier for the surgical procedure and the implantable device.</p>	<p>ASC</p>	<p>Carrier</p>
<p>Non-implantable prosthetic devices</p> <p>ASCs who furnish non-implantable prosthetic devices to patients, are treated as suppliers, and all the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p> <p>An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.</p>	<p>DMERC</p>
<p>Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs [new technology intraocular lenses]), and accessories</p> <p>ASCs may bill and receive separate payment for prosthetic devices (other than intraocular lenses [IOLs]) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule.</p> <p>An intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate.</p> <p>ASCs may receive additional payment for approved NTIOLs that are furnished in an ASC during or subsequent to certain cataract procedures.</p>	<p>ASC</p>	<p>Carrier</p>
<p>Ambulance services</p> <p>ASCs who furnish ambulance services, may obtain approval as ambulance suppliers to bill covered ambulance services</p>	<p>Certified ambulance supplier</p>	<p>Carrier</p>
<p>Leg, arm, back, and neck braces</p> <p>These items of equipment are not included in the ASC facility payment amount, but are covered under Part B.</p> <p>ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p>	<p>DMERC</p>

Items or Services	Who Receives Payment	Submit Bills To
<p>Artificial legs, arms, and eyes</p> <p>These items of equipment are not included in the ASC facility payment rate, but are covered under Part B.</p> <p>ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to suppliers apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier	DMERC
<p>Services furnished by an independent laboratory</p> <p>Only very limited numbers, and types, of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate.</p> <p>Since coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals is limited to facilities that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests performed directly by an ASC are not considered ASC facility services (in fact are usually not covered under Medicare).</p> <p>ASC laboratories must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services.</p> <p>If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.</p>	Certified lab. ASCs can receive lab certification and a CLIA number.	Carrier
<p>Procedures NOT on the ASC list</p> <p>Physicians bill the carrier for the procedures and any implantable prosthetics/DME, using the ASC as the place of service</p>	Physician	Carrier

Additional Information

You can find more information about services not included in the ASC facility rate (and the coverage of such services) by reviewing CR5026, which is available on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R942CP.pdf>

The revised *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) are attached to CR5026.

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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

Clinical Laboratory Improvement Act (CLIA)

New Waived Tests

Reference: Trans. 947, CR #5083, 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

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.

Description	CPT Code/Modifier	Effective Date
Icon Mono	86308QW	January 24, 2005
Bayer Clinitek Status Urine Chemistry Analyzer	81003QW 82570QW	September 7, 2005
Biotechnostix, Inc. Rapid Response FSH One Step Menopause Test Device	83001QW	January 10, 2006
First Check Diagnostics First Check Multi Drug Cup	80101QW	January 17, 2006
Axis-Shield Afinion AS100 Analyzer	83036QW	February 17, 2006
RAC Medical Clarity MONO Mononucleosis Rapid Test Device (Whole Blood)	86308QW	February 22, 2006
First Check Diagnostics First Check 12 Drug Test	80101QW	February 22, 2006
Biotechnostix Rapid Response Multi-Drug, Multi-Line Screen Test Card with Integrated Cup	80101QW	February 27, 2006
Biotechnostix Rapid Response One Step Multi-Drug, Multi-Line Screen Test Device	80101QW	March 3, 2006

Coding & Coverage

Cardiac Rehabilitation Programs

Reference: Trans. 909 and 52, CR #4401, Pub. 100-04 and 100-03, Medlearn Matters Number: MM4401

Provider Types Affected

All providers who bill Medicare for cardiac rehabilitation services

Impact to You

Effective on and after March 22, 2006, Medicare has expanded coverage for cardiac rehabilitation programs to include three new indications, and has extended the time frame for performing the services to include up to 36 sessions.

What You Need to Know

CR4401 updates the *National Coverage Determination (NCD) Manual*, Publication 100-03, Section 20.10, Cardiac Rehabilitation Programs (March 22, 2006), to include three newly covered indications: 1) heart valve repair/replacement; 2) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; and 3) heart or heart-lung transplant. It also extends the program's possible duration to a total of 36 sessions (generally, two to three sessions per week for 12 to 18 weeks) and lists the services required to provide a comprehensive program. CR4401 also updates the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140 to include billing requirements and language regarding physician supervision.

What You Need to Do

Make sure that your billing staffs are aware of these coverage changes in the Cardiac Rehabilitation Program.

Background

Phase II cardiac rehabilitation, as described by the U.S. Public Health Service, is a comprehensive, long-term program including medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated 1-3 weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

CR4401 updates *National Coverage Determinations (NCD) Manual* (100-03), Section 20.10 (effective for cardiac rehabilitation services provided on or after March 22, 2006) to:

- Expand the clinical indications for coverage;
- Extend the program's possible duration;
- Simplify the language regarding physician supervision;
- List the services required to provide a comprehensive program; and
- Update the relevant billing and claims related instructions found in the *Medicare Claims Processing Manual* (Publication 100.04).

CMS has historically covered cardiac rehabilitation services for patients who have: (1) a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) coronary artery bypass surgery; and /or (3) stable angina pectoris. The updated NCD now provides coverage for these three indications and adds three additional ones.

Expanded Coverage

Effective for services performed on or after March 22, 2006, Medicare covers cardiac rehabilitation exercise programs for patients who meet the following criteria:

- Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
- Have had coronary bypass surgery; or
- Have stable angina pectoris; or
- Have had heart valve repair/replacement; or
- Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- Have had a heart or heart lung transplant.

Further, the updated policy also now allows up to 18 weeks for a beneficiary to receive their maximum of 36 cardiac rehabilitation services (Patients generally receive two to three sessions per week for 12 to 18 weeks).

Please note that additional services may be covered at the discretion of the local Medicare contractor, but may not exceed 72 sessions within a 36-week period.

Clarification of Physician and Facility Requirements

The updated policy also clarifies language regarding physician supervision and facility requirements and the physician's physical location during the rehabilitation services. Specifically the NCD requires that:

- The program must be staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease; and
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator.

The *Medicare Claims Processing Manual* instructs that:

- Cardiac rehabilitation programs shall be performed incident to physician's services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, chapter 6, section 2.4.1, and Pub. 100-02, chapter 15, section 60.1.

Coding Requirements

This CR also changes the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140, to update the relevant billing and claims related instructions, and points out the following applicable HCPCS codes:

- **93797** - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session); and
- **93798** - Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).

You should note that your carriers and FIs will apply current payment methodologies, rates, and payments policies for cardiac rehabilitation services when these services are performed according to the new policy stated in this CR. However, they will not search and adjust claims that have already been processed unless brought to their attention.

Additional Information

The revision of Section 20.10 of the *Medicare National Coverage Determinations Manual* (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. Remember that:

- NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR 405.1064, effective May 1, 2005);
- An NCD that expands coverage is also binding on a Medicare advantage organization; and
- In addition, an administrative law judge may not review an NCD. (See 1869(f)(1)(A)(i) of the Social Security Act.

You may view CR4401, Transmittal 52, the revised *Medicare National Coverage Determinations Manual*, Chapter 1 - Coverage Determinations, Part 1, Section 20.10 (Cardiac Rehabilitation Programs – effective March 22, 2006), on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R52NCD.pdf>

You may view CR4401, Transmittal 909, the revised *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 140 (Cardiac Rehabilitation Programs) and 140.1 (Coding Requirements), on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R909CP.pdf>

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

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

Nesiritide for Treatment of Heart Failure Patients

Reference: Trans. 218 and 51, CR #4312, Pub. 100-20 and 100-03, Medlearn Matters Number: MM4312

Note: This article was revised on May 19, 2006, to clarify some of the language regarding the use of Nesiritide.

Provider Types Affected

Providers and physicians that submit claims to Medicare fiscal intermediaries (FIs) and carriers for Nesiritide when provided as a treatment for chronic heart failure

Key Points

- Effective for dates of service on or after March 2, 2006, the Centers for Medicare & Medicaid Services (CMS) will deny coverage of Nesiritide for the treatment of chronic heart failure in Medicare beneficiaries. For billing guidelines about the non-covered use of Nesiritide, please refer to the *Additional Information* section of this article.
- CMS has determined that there is insufficient evidence to conclude that the use of Nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting.
- This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the FDA labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of Nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.
- For claims submitted to FIs, the requirement to deny Nesiritide for chronic heart failure will only affect 13X and 85X Type of Bill (TOBs).
- 11X and 12X TOBs should be rejected.
- CMS recommends that FIs create medical policy parameters to deny outpatient claims for Nesiritide for chronic heart failure in the absence of acutely decompensated heart failure.
- CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (11X and 12X) when billed with Nesiritide for chronic heart failure.
- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and Nesiritide is administered under a DRG payment, the administration of Nesiritide should not be the sole basis for denial of the entire inpatient claim.
- The provider will be held liable unless occurrence code 32 is present on the claim, or modifier GA is present on the line on an outpatient bill when Nesiritide is used to treat chronic heart failure without documented evidence of acute decompensation.
- All other indications for the use of Nesiritide not otherwise indicated as non-covered (other off-label uses or use consistent with the current Food and Drug Administration (FDA) indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.
- This addition to Chapter 1, Section 200.1, of the *Medicare National Coverage Determinations Manual* (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).
- NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

Background

Nesiritide is FDA-approved for the short-term intravenous treatment of patients with acutely decompensated CHF who have dyspnea (shortness of breath) at rest or with minimal activity. Recent published studies of Nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with Nesiritide.

In addition, an independent advisory panel of cardiac experts sponsored by Scios, manufacturer of Natrecor® (Nesiritide), recommends that *“The use of Nesiritide should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure who have dyspnea at rest.....”*

Additional Information

Claims submitted with Healthcare Common Procedure Coding System (HCPCS) code J2325 (Injection, Nesiritide) with International Classification of Diseases (ICD-9) codes of:

- 428.0, 428.1, 428.20, 428.22, 428.30, 428.32, 428.40, 428.42, or 428.9; **and not accompanied by:**
- 428.21, 428.23, 428.31, 428.33, 428.41, or 428.43, **will be denied.**

Denied claims will be returned with the following claims adjustment codes:

- **Reason Code:** These are non-covered services because this is not deemed a “medical necessity” by the payor;
- **Remark Code M76:** Missing/incomplete/invalid diagnosis or condition.

Contractors shall apply the following Medicare Summary Notice messages:

- **15.20:** The following policy [NCD 200.1] was used when we made this decision.
- **15.4:** The information provided does not support the need for this service or item.

Contractors shall not search for, but may adjust, claims brought to their attention with dates of service March 2, 2006, through implementation.

Relevant Links

CR4312 is the official instruction issued to your FI or carrier, regarding changes mentioned in this article. There are two transmittals related to CR4312. One is transmittal number R51NCD, which relates to the NCD and it may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R51NCD.pdf> on the CMS web site. The second transmittal, R218OTN, relates to Medicare claims processing instructions, and it can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R218OTN.pdf>

Please refer to your local FI or 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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

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

Reference: Trans. 911 and 53, CR #5022, Pub. 100-04 and 100-03, Medlearn Matters Number: MM5022

Provider Types Affected

Providers, physicians, and suppliers that bill Medicare contractors (fiscal intermediaries (FIs) and carriers) for their services

Key Points

- This article is based on CR5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities “approved facilities” web site link in Publication 100-03, *The National Coverage Determinations Manual*. The list is now available on the CMS web site at:
<http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp>
- Claims that are being billed for Category B IDE studies and post-approval studies, per CR1660 (effective July 1, 2001) and CR3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR3811 (Effective March 17, 2005). The links to CR1660 and the Medicare Learning Network (MLN) articles relating to CR3489 and CR3811 can be found in the *Related Links* section below.
- CMS created a new section in the *Medicare Claims Processing Manual* specific to carotid stents. Please refer to this new section in the manual attachment to CR5022, (Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 32, Sections 150.1-150.3) for more information about PTA for implanting the carotid stent. (This includes information on CR660, CR 3489 and CR3811.)

Background

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

Please refer to the manual attachment to CR5022, Transmittal 53, (Publication 100-03, *The Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 20.7) for more information about the nationally covered indications for PTA concurrent with carotid stent placement, and for facilities accepted for services related to CAS with embolic protection. This is available on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf>

Category B IDE Study Claims and Post-approval Study Claims

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

- Billed under a Category B IDE study (identified by a six-digit IDE number preceded by a “G,” i.e., G123456); or a
- Billed under an FDA-approved post-approval study (identified by a six-digit PMA number preceded by a “P,” i.e., P123456)
- Previously denied due to the unintended application of the “approved” facility edit created per CR 3811 that are brought to your FI’s or carrier’s attention will be adjusted (per CR1660 for Category B IDE Study Claims, and CR3489 for Post-approval Study Claims).

CAS with Embolic Protection Claims

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

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

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

Related Links

CR1660, *Claims Processing Instructions for Clinical Trials on Carotid Stenting with Category B Investigational Device Exemptions (IDEs)* can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/Downloads/AB0174.pdf>

MM3489, *Percutaneous Transluminal Angioplasty (PTA)* can be found at the following link on the CMS web site:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf>

MM3811, *Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA)* is located on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf>

CR5022 is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM5022. CR5022 may be found by going to Transmittal 911CP at

<http://www.cms.hhs.gov/Transmittals/downloads/R911CP.pdf> for the claims processing instructions and to Transmittal 53NCD for the NCD Manual section, which is on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf>

Please refer to your local FI or carrier 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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

Additional Clarification of CR 3816 Business Requirements – Low Vision Rehabilitation Demonstration

Reference: Trans. 46, CR #5023, Pub. 100-19, Medlearn Matters Number: MM5023

Provider Types Affected

Physicians and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for treatment provided to beneficiaries under the Low Vision Rehabilitation Demonstration Project

Providers Action Needed

This article is based on Change Request (CR) 5023 and this article actually revises the article for CR3816 by providing specific information clarifying billing instructions as directed in the Administrative Simplification Compliance Act (ASCA). Be aware that:

- National Provider Identification numbers (NPI) replace physician UPIN numbers by May 23, 2007.
- CR3816 for the Low Vision Rehabilitation Demonstration states that **providers** are to document the plan of care by indicating the date the plan was developed or reviewed in Block 19 (Reserved for Local Use) of the CMS-1500 or its electronic equivalent.
- This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.
- **Facilities** must document the date the plan of care was established or reviewed using occurrence code 17 on CMS-1450 or its electronic equivalent.
- This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.

Background

According to CR3816, the date the plan of care was established was to be placed in Block 19 of the CMS 1500 form. However, there is no place for this information in the electronic claims form. Therefore, this requirement has been removed whether submitting a paper claim or an electronic claim by providers or facilities.

In addition, although the business requirements in CR3816 mention use of remittance advice messages, and the background makes reference to using the most appropriate Medicare summary notice (MSN) messages unless specified otherwise in the business requirements, there is no corresponding reference to the remittance advice message in the background.

Please note that your carrier/FI will use the most appropriate remittance advice and remark codes when denying a claim unless otherwise specified in CR3816.

Implementation

The implementation date for the instruction is July 28, 2006.

Additional Information

For details of enforcement of the ASCA, please see related MLN Matters article MM3440, “Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims,” on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3440.pdf>

To view the MLN Matters article related to CR3816, go on the CMS web site to:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3816.pdf>

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

<http://www.cms.hhs.gov/Transmittals/downloads/R46DEMO.pdf>

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

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

Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine

Reference: Trans. 921, CR #5037, Pub. 100-04, Medlearn Matters Number: MM5037

Provider Types Affected

Physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for Influenza and/or PPV vaccines and vaccine administration

Providers Action Needed

This article and Change Request (CR) 5037 provide specific information regarding payment for Influenza and/or PPV vaccines and their administration. Effective for dates of service on or after October 1, 2006, the following are the new instructions:

- Ø **Report diagnosis code V06.6** on claims that contain Influenza Virus and/or PPV vaccines and their administration when the purpose of the visit was to **receive both** vaccines.
- Ø Continue reporting **diagnosis code V03.82** on claims that contain only PPV vaccine and its administration.
- Ø Continue reporting **diagnosis code V04.81** on claims that contain only Influenza Virus vaccine and its administration.
- Ø Use **CPT code 90660** on claims when **billing for** Influenza Virus vaccine, live, for Intranasal use.
- Ø Neither a deductible nor a coinsurance will be applied to Influenza Virus vaccine, CPT code 90660, and its administration.
- Ø Use **HCPCS code G0008** when billing for the **administration of code 90660**.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding payment for Influenza and/or PPV vaccines and its administration. Currently, providers are required to report diagnosis codes V03.82 for PPV and its administration and diagnosis code V04.81 for Influenza Virus vaccine and its administration. This instruction allows the reporting of diagnosis code V06.6 in place of V03.82 and V04.81 when reporting Influenza Virus and/or PPV vaccines when the purpose of the visit was to receive both vaccines. In addition, this instruction requires Medicare carriers/FIs to accept claims containing CPT code 90660 for the Influenza Virus vaccine.

Implementation

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

Additional Information

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

<http://www.cms.hhs.gov/Transmittals/downloads/R921CP.pdf>

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

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

Full Replacement of CR4349, Hold on Medicare Payments. CR4349 Is Rescinded

Reference: Trans. 944, CR #5047, Pub. 100-04, Medlearn Matters Number: MM5047

Note: This article was revised on May 11, 2006, to reflect a new CR release date, transmittal number and CR5047 web address. These were changed to reflect that CR5047 was revised by CMS on May 10. All other information in the article remains the same.

Provider Types Affected

Providers and physicians who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) for their services

Key Points

- A brief hold will be placed on Medicare payments for ALL claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer (MSP) claims) for the last 9 days of the Federal fiscal year, i.e., September 22, 2006-September 30, 2006.
 - ∅ In essence, no payments on claims will be made from September 22-30, 2006. Providers need to be aware of these payment delays, which **are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006.**
 - ∅ Accelerated payments using normal procedures will be considered
- No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- **All** claims held as a result of this one-time policy that would have otherwise been paid on one of these 9 days will be paid on **October 2, 2006.**

Additional Information

This policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments, cost reports settlements, and other non-claim payments.

Additionally, Medicare contractors will continue to apply the fourteen day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare FIs, RHHIs or carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Please note that:

- Payments will not be staggered; and
- No advance payments during the 9-day hold will be allowed.

CR5047 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR5047 may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf>

Please refer to your local FI/RHHI or carrier 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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

Bariatric Surgery for Morbid Obesity

Reference: Trans. 931 and 54, CR #5013, Pub. 100-04 and 100-03, Medlearn Matters Number: MM5013

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to bariatric surgery

Impact to You

This article is based on Change Request (CR) 5013, which modifies the *Medicare National Coverage Determination Manual* (NCDM, Sections 40.5 and 100.1) and adds section 150 to Chapter 32 of the *Medicare Claims Processing Manual* to be consistent with the new Centers for Medicare & Medicaid Services (CMS) policy for bariatric surgery.

What You Need to Know

Effective for services on or after February 21, 2006, Medicare will cover open and laparoscopic Roux-en Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB) and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) if certain criteria are met and the procedure is performed in an approved facility.

In addition, effective for services performed on or after February 21, 2006, Medicare has decided that open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding are nationally non-covered for Medicare.

What You Need to Do

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

Background

Bariatrics is the branch of medicine dealing with obesity, and bariatric surgery can be an effective treatment for patients who have been unsuccessful with diet and exercise and have comorbid conditions such as:

- Coronary artery disease;
- Diabetes; and
- Sleep apnea.

Bariatric surgery procedures are performed to treat many comorbid conditions associated with obesity, and two types of surgical procedures are employed:

- Malabsorptive surgical procedures divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and adsorption of nutrients cannot occur; and
- Restrictive surgical procedures restrict the size of the stomach and decrease intake.

Some surgeries combine both of these types of procedures, and brief descriptions of bariatric surgery procedures are included in the *Additional Information* section of this article. Also, see the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Chapter 1, Part 2, Section 100.1 (Bariatric Surgery for Morbid Obesity (Effective February 21, 2006), Subsection A (General)), attached to CR5013.

Note: Bariatric surgery is recommended only for individuals with health concerns related to their obesity

CMS has determined the evidence is adequate to conclude that:

- **If** a Medicare beneficiary has documented in their medical record that they:
 - Ø Have a body-mass index (BMI) > 35, with at least one co-morbidity related to obesity; **and**
 - Ø Have been previously unsuccessful with medical treatment for obesity;
- **Then** the following procedures (performed on or after February 21, 2006) are considered reasonable and necessary:
 - Ø Open and laparoscopic Roux-en-Y gastric bypass (RYGBP);
 - Ø Laparoscopic adjustable gastric banding (LAGB); and
 - Ø Open and laparoscopic biliopancreatic diversion (BPD) with duodenal switch (DS).

Approved Facilities

In addition, CMS has determined that covered bariatric surgery procedures are reasonable and necessary **only** when performed at facilities certified by:

- The American College of Surgeons ((ACS) <http://www.facs.org>) as a Level 1 Bariatric Surgery Center (BSC; program standards and requirements in effect on February 15, 2006); or
- The American Society for Bariatric Surgery ((ASBS) <http://www.asbs.org>) as a Bariatric Surgery Center of Excellence (BSCOE; program standards and requirements in effect on February 15, 2006).

A list of approved facilities and their approval dates will be listed and maintained on the CMS coverage web site at:

<http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage>

This information will also be published in the Federal Register.

When services are performed in an unapproved facility, Medicare will deny the claim with a claim reason adjustment code of 58. (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.)

For providers to avoid liability for charges when services are performed in an unapproved facility, physicians must have the beneficiary sign an Advanced Beneficiary Notice (ABN), and hospitals, including critical access hospitals, must have the beneficiary sign a Hospital Issued Notice of Non-coverage (HINN).

Non-Covered Procedures

The evidence is not adequate to conclude that the following bariatric surgery procedures are reasonable and necessary; therefore, the following procedures are non-covered for all Medicare beneficiaries:

- Open vertical banded gastroplasty
- Laparoscopic vertical banded gastroplasty
- Open sleeve gastrectomy
- Laparoscopic sleeve gastrectomy
- Open adjustable gastric banding.

Changes in Manuals

The *Medicare Claims Processing Manual* (Pub.100-04, Chapter 32 (Billing Requirements for Special Services), Section 150 (Billing Requirements for Bariatric Surgery for Morbid Obesity)) is being added to reflect the new coverage for bariatric surgery.

In addition, the Medicare *National Coverage Determination Manual* (NCDM, Pub. 100-03, Chapter I, Sections 40.5 and 100.1) are being modified to be consistent with the new CMS policy for bariatric surgery. These revisions are attached to CR5013.

The revision of the NCDM will include a reference to the covered surgical procedures, and revise the obesity policy with the final bariatric surgery policy. The modified obesity policy will read as follows (changes bolded and italicized):

“Obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Non-surgical services in connection with the treatment of obesity are covered when such services are an integral and necessary part of a course of treatment for one of these medical conditions.

Certain designated surgical services for the treatment of obesity are covered for Medicare beneficiaries who have a BMI • 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity.”

Treatments **for obesity alone** remain non-covered, and the following non-coverage determinations in the *National Coverage Determination Manual* (NCDM, Chapter 1, Part 2; http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf) remain unchanged:

- Section 100.8 (Intestinal Bypass Surgery); and
- Section 100.11 (Gastric Balloon for Treatment of Obesity).

Additional Instructions

CR5013 further instructs your carrier and/or fiscal intermediary to:

- Accept the following Healthcare Common Procedure Coding System (HCPCS) as of February 21, 2006:
 - Ø 43770 - Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)
 - Ø 43644 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
 - Ø 43645 - Laparoscopy with gastric bypass and small intestine reconstruction to limit absorption. (Do not report 43645 in conjunction with 49320, 43847.)
 - Ø 43845 - Gastric restrictive procedure with partial gastrectomy, pyloruspreserving duodenoileostomy and ileoieostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
 - Ø 43846 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less Roux-en-Y gastroenterostomy. (For greater than 150 cm, use 43847)(For laparoscopic procedure, use 43644)
 - Ø 43847 - With small intestine reconstruction to limit absorption;
- Accept HCPCS codes 43770, 43644, 43645, 43845, 43846 and 43847 submitted with at least one of the following diagnosis codes: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; or 278.01. (Claims will be denied without an appropriate diagnosis code.);
- Accept International Classification of Diseases, Ninth Revision (ICD-9) procedure codes 44.38, 44.39, 44.95, 43.89, 45.51, and 45.91, when the following diagnosis codes are reported: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; and 278.01. (Claims will be denied without an appropriate diagnosis code and none of the V diagnosis codes for BMI • 35 or 278.01 for morbid obesity can be the principal diagnosis on an inpatient Medicare claim); and
- Accept the following ICD-9 Procedure Codes as of February 21, 2006:
 - Ø 44.38 - Laparoscopic gastroenterostomy (laparoscopic Roux-en-Y);
 - Ø 44.39 - Other Gastroenterostomy (open Roux-en-Y); and
 - Ø 44.95 - Laparoscopic gastric restrictive procedure (laparoscopic adjustable gastric band and port insertion).

Important Note: There is not a distinction between laparoscopic and open biliopancreatic diversion (BPD) with duodenal switch (DS) for the inpatient setting. The codes would apply to the open approach as follows:

1. 43.89 Other partial gastrectomy;
2. 45.51 Isolation of segment of small intestine; and
3. 45.91 Small to small intestinal anastomosis.

Should claims be denied for failure to have the appropriate diagnosis code, the carrier/FI will use claim adjustment reason code #167 to denote “This/these diagnosis(es) is (are) not covered.”

Note that 44.68 (Laparoscopic gastroplasty (vertical banded gastroplasty)) is non-covered for Medicare effective February 21, 2006.

Additional Fiscal Intermediary Billing Requirements

The FI will pay for Bariatric Surgery only when the services are submitted on type of bill (TOB) of 11X.

The type of facility and setting determines the basis of payment:

- For services performed in inpatient hospitals, TOB 11X, IPPS payment is based on the DRG.
- For services performed in CAH inpatient hospitals, TOB 11X, on 101% of facility specific per visit rate.
- For services performed in IHS inpatient hospitals TOB 11X under IPPS based DRG.
- For services performed in IHS critical access hospitals, TOB 11X, under 101% facility specific per diem rate.

Implementation

The implementation date for CR 5013 is May 30, 2006 for physician claims billed to Medicare carriers and October 2, 2006, for hospital claims billed to FIs.

Additional Information

For complete details, please see the official instruction, CR5013, issued to your carrier/intermediary regarding this change. There will be two parts to this CR, one for the NCD and one for the claims processing instruction. The NCD, which includes descriptions of the Bariatric Surgery procedures, is at <http://www.cms.hhs.gov/Transmittals/downloads/R54NCD.pdf> and the claims processing instruction may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R931CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

Payment for Carotid Artery Stenting (CAS) Post Approval Extension Studies

Reference: *Trans. 951, CR #5088, Pub. 100-04, Medlearn Matters Number: MM5088*

Provider Types Affected

Physicians or providers submitting claims to carriers or fiscal intermediaries (FIs) for CAS post approval extension studies.

Impact on Providers

This article is based on Change Request (CR) 5088, which informs providers that the Centers for Medicare & Medicaid Services (CMS) has determined that all extension studies must be reviewed by the Food and Drug Administration (FDA). The FDA will issue an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. Upon receipt of this letter and review of the extension study protocol, the CMS will issue a letter to the study sponsor indicating that the study under review will be covered by Medicare.

Background

CMS issued Change Request (CR) 3489 (Transmittal 314, dated October 12, 2004; <http://www.cms.hhs.gov/transmittals/Downloads/R25NCD.pdf>) to provide Medicare contractors (carriers and/or FIs) with instructions for processing claims for CAS procedures performed in FDA-approved post-approval studies. As the post-approval studies began to end, CMS received requests to extend their coverage.

CMS reviewed the extension requests and has determined that patients participating in post-approval extension studies are also included in the currently covered population of patients participating in FDA-approved post-approval studies (*Medicare National Coverage Determinations Manual*, Pub. 100-3, Chapter 1, Part 1, Section 20.7; available on the CMS web site at:

http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf

To grant approval for post-approval studies, the FDA reviews each study protocol, and once approval is granted, the FDA issues a formal approval letter to the study sponsor.

Extensions of post-approval studies are not subject to approval by the FDA because they surpass the post-approval study requirements identified in the conditions of approval for post-approval studies. **Therefore**, since the FDA cannot approve these extension studies, **individual Post-Market Approval (PMA) numbers cannot be issued to separately identify each study**. Currently, **in order to receive reimbursement for procedures performed as part of a carotid artery stenting post-approval study, providers must include the FDA-issued PMA number on each claim** to indicate participation in a specific study.

CMS has determined that the FDA must review all extension study protocols. If the FDA determines the extension study protocol is scientifically valid, the FDA will:

- Issue an acknowledgement letter stating that the extension study protocol is scientifically valid; and
- Generate clinically relevant post-market data.

CMS will issue a letter to the study sponsor indicating that the study under review will be covered by Medicare upon receipt of the FDA's:

- Acknowledgement letter; and
- Review of the extension study protocol indicating the study protocol is scientifically valid.

Because an individual PMA number cannot be assigned by the FDA to each extension study, these studies will use the PMA number assigned to the original FDA-approved post-approval study (i.e., CAPTURE 2 shall use the PMA number assigned to CAPTURE 1).

To receive Medicare coverage for patients participating in post-approval extension studies, providers should follow the process for informing Medicare contractors of their participation as established in CR3489 (Transmittal 314, dated October 12, 2004; <http://www.cms.hhs.gov/transmittals/Downloads/R25NCD.pdf>). There is also an MLN Matters article related to CR3489 on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf>

Providers should submit to their Medicare contractor:

- The FDA acknowledgement letter;
- The CMS letter providing coverage for the extension study to their contractor; and
- Any other materials their Medicare contractor would require for FDA-approved post-approval studies.

In response, the provider's Medicare contractor will issue a letter assigning an effective date for each facility's participation in the extension study.

Providers:

- **Should follow** the billing instructions from CR3489 (Transmittal 314, dated October 12, 2004);
- **May bill** for procedures performed in the extension study for dates of service on and after the assigned effective date; and
- **Must bill** using the most current ICD-9 CM procedure codes **when billing FIs**. For example, when billing a CAS extension study with dates of service July 1, 2006 through July 15, 2006, the provider should bill the most current ICD-9 CM procedure codes 00.61 and 00.63 (instead of the 39.50 and 39.90 procedure codes published in CR 489).

Please note that:

- Providers participating in the Capture 2 post-approval extension study must submit copies of two letters to their local contractor, i.e., an FDA acknowledgement letter and a CMS coverage letter;
- After receiving the above letters, the Medicare contractor will issue a letter to the provider assigning an effective date for participation in the extension study;
- Providers may bill for procedures performed in the extension study for dates of service on and after the assigned effective date;
- Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention; and
- Providers should continue to follow the guidelines for processing post-approval study claims as directed in Change Request 3489, Transmittal 314, issued October 15, 2004.

Implementation

The implementation date for this instruction is June 12, 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/R951CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

Competitive Acquisition Program (CAP)

Competitive Acquisition Program (CAP) for Part B Drugs Physician Election

Reference: Trans. 932, CR #4404, Pub. 100-04, Medlearn Matters Number: MM4404

Provider Types Affected

Physicians billing Medicare carriers for certain Part B drugs and biologicals under the Medicare CAP program

Impact to You

This article is based on Change Request (CR) 4404, which provides instruction for physicians who wish to elect the CAP to obtain certain Medicare Part B drugs and biologicals.

What You Need to Know

Physicians will be given an opportunity to elect to participate in the CAP on an annual basis, and practitioners who elect to participate in the CAP will be required to remain in the program at least one calendar year except under certain circumstances.

Physicians who elect to participate in the CAP will be required to complete a CAP election agreement. In 2006, the election period will occur from May 8, 2006, to June 2, 2006, and the term of election will run from July 1 to December 31, 2006.

What You Need to Do

See the *Background Section* of this article for further details regarding the physician election of the CAP program for Part B drugs and biologicals.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d) <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or Prospective Payment System (PPS) basis.

Beginning with drugs administered **on or after July 1, 2006**, physicians will be given a choice between:

- Buying and billing these drugs under the average sales price (ASP) system; or
- Obtaining these drugs from CAP vendors selected in a competitive bidding process.

Ø For 2006 the CAP approved vendor is Bioscrip, Vendor Identification Number Q103.

http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage

Note: For purposes of the CAP, a physician includes individuals defined under the Social Security Act (Section 1861(r); http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) and other practitioners who are authorized to provide physician services under 1861(s) and who can, within their state's scope of practice, prescribe and order drugs covered under Medicare Part B.

This article is based on Change Request (CR) 4404, which in addition to including the final physician election agreement included as an attachment, provides information and instructions for the implementation of the CAP pertaining to the physician election process as outlined in:

CR4064 (Transmittal 777, dated December 9, 2005; <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>); and

CR4309 (Transmittal 839, dated February 6, 2006; <http://www.cms.hhs.gov/transmittals/downloads/R839CP.pdf>)

The MLN Matters article corresponding to CR4064 can be found at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>; and the article corresponding to CR4309 can be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>

In order to implement the annual physician election process, the Centers for Medicare & Medicaid Services (CMS) instructed your carrier in CR4064 to:

- Accept physician election applications immediately following the posting of approved CAP vendors on the CMS web site;
- Create an initial list of all the physicians and practitioners **who have elected to participate** in CAP;
- Forward this information to the designated CAP vendor carrier Noridian; and
- Repeat this process annually.

Annual Physician Election Process

Physicians will be given an opportunity to elect to participate in the CAP on an annual basis, and practitioners who elect to participate in the CAP will be required to remain in the program at least one calendar year. The CAP physician election form is included with CR4404 and can be found online at:

http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage

Participating physicians who wish to continue their participation in CAP for subsequent years would do so by submitting an abbreviated agreement, which would also permit the practitioners to change approved CAP vendor or CAP drug category.

CAP Participating Physician Requirements

Physicians who elect to participate in the CAP will be required to complete a CAP election agreement (final attached to CR4404) assuring full and continued compliance with the participating CAP physician requirements per Title 42 CFR (Code of Federal Regulations) Part 414 Section 908 (<http://www.gpoaccess.gov/cfr/retrieve.html>) of Medicare regulations.

If a physician makes the decision to participate in the CAP, payment for the administration of any CAP drug or biological may be made only on an assignment related basis. Additional details are available in the *Medicare Claims Processing Manual*, Chapter 17, Sections 100-100.8.2, which are included in Attachment A of CR4404.

Application Process

Physicians who would like to participate in the program can obtain the following information on the CMS web site at:

www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

- The CAP physician election form;
- The list of the approved CAP vendors; and
- The specific National Drug Codes (NDCs) that the vendors will provide.

Once the election agreement is completed, it must be submitted to the practitioner's local Medicare carrier.

The physician election process for 2006 shall operate from May 8 to June 2. For subsequent calendar years, CMS anticipates that the physician election process will be between October 4 and November 15 of each calendar year to meet operational timeframes for CAP vendors and claim processing contractors.

Note: The CAP election agreement must be postmarked by June 2 for 2006 election period.

The 2006 CAP operational period will be for July 1- December 31, 2006.

Group Election

When members in a group practice bill Medicare using the groups PIN, they must commit as a group practice to elect to participate in the CAP.

In order for a physician to "buy and bill" separately from the group he or she must not have reassigned his or her benefits to the group, and must be billing using his or her individual PIN.

If a physician in that situation elects to participate in the CAP as an individual, he or she would complete the CAP physician election form with his or her individual PIN, and other requested information.

Mid-Year Changes

Physicians are permitted to select another approved CAP vendor or leave the CAP in mid-year if any one of the following occur:

- The approved CAP vendor selected by the physician leaves the program;

- The participating physician leaves a group practice, or a new physician enters a group practice that had selected the approved CAP vendor;
- The participating physician relocates to another competitive acquisition area (Although multiple CAP competitive areas are anticipated, there is one drug category and one geographic area for the 2006 through 2008 contract period.);
- The physician is newly enrolled in the Medicare program and elects to participate in the CAP within 90 days of enrollment; or
- The approved CAP vendor refuses to ship to the participating CAP physician because the conditions of 42 CFR § 414.914(h) were met, the physician may withdraw from the CAP category for the remainder of the year upon notice to CMS and the approved CAP vendor.

CAP Physician Election Agreement

The final CAP physician election agreement is included as an Attachment to CR 4404. Providers interested in participating in the CAP must download the form from the CAP website and complete pages 1, 5, and 6 of the agreement. If a physician has more than one practice location additional copies of page 6 must be submitted. For group practices all physician members who will be participating in the CAP and billing under the group PIN must be listed, however only one election agreement should be submitted for each group practice. An authorized representative must sign the form on behalf of the individual or group practice members on page 5. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider or must hold a position of similar status or authority within the provider's organization.

In summary, CR4404 instructs your carrier to receive the CAP physician election agreement forms submitted by physicians who wish to participate in the CAP in their area either during the annual election process or because of a mid-year change.

Please note that:

- Claims submitted by a physician for CAP drugs with a date of service after the effective date the physician disenrolled from the CAP will be processed as ASP claims.
- Claims submitted by the vendor for CAP drugs with a date of service prior to the effective date the physician disenrolled from the CAP will be processed as CAP claims.

Implementation

The implementation date for this instruction is May 30, 2006.

Additional Information

Attached to CR4404 is the Competitive Acquisition Program (CAP) Physical Election Agreement for Medicare Part B Drugs.

For complete details, please see CR4044 on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R932CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

The list of CAP drugs can be found at:

http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage

Announcement of Competitive Acquisition Program (CAP) Vendor Selection Press Release

Reference: JSM CI 3876-06413, 04-21-06

The Centers for Medicare & Medicaid Services' (CMS) has announced approved drug vendor information for the Competitive Acquisition Program (CAP.) View the CMS web page dedicated to providing all the latest CAP news for health care providers at <http://www.cms.hhs.gov/CompetitiveAcquisforBios> on the web. This page is your source for news on CAP including how to participate in the CAP program. Bookmark this page as new information and resources will continue to be posted.

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>

DMEPOS

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

Reference: Trans. 928, CR #5017, Pub. 100-04, Medlearn Matters Number: MM5017

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.

Providers Action Needed

This article is based on Change Request (CR) 5017 and provides specific information regarding the quarterly update for the July 2006 DMEPOS Fee Schedule.

Background

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

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

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 the Update

Changes made in this update include the following:

The fee schedule amounts for the following HCPCS codes are added to the fee schedule file as part of this update and are effective for claims with dates of service on or after January 1, 2006:

L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L5703, L5858, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405, E1238, E1812, E2291, E2292, E2293, E2294

The fee schedule amounts for HCPCS code **K0733**, *Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)* are added to the fee schedule file on July 1, 2006, and is effective for claims with dates of service on or after July 1, 2006.

The fee schedule amounts for HCPCS code **E0762**, *Transcutaneous electrical joint stimulation device system, includes all accessories*, are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006. In addition, the payment category for code **E0762** is being revised to move the joint stimulation device from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective July 1, 2006.

The fee schedule amounts for HCPCS codes **L6694 and L6698** are added to the fee schedule file on July 1, 2006, and are effective for claims with dates of service on or after January 1, 2005.

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

Code **E0705** (Transfer Board or Device, Any Type, Each) was added to the HCPCS effective January 1, 2006. The payment category for E0705 is being revised to the inexpensive and routinely purchased payment category and the fee schedule amounts for previous HCPCS code E0972 will be crosswalked to code E0705 for use in paying claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code **K0606** (Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type) are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

The fee schedule amounts for HCPCS code **E1812** (Dynamic Knee, Extension/Flexion Device with Active Resistance Control) are added to the fee schedule file on July 1, 2006, and are effective for claims submitted with dates of service on or after January 1, 2006.

As part of this update, the common working file category for HCPCS code **B4185** will be switched from CWF category 9 to CWF category 20, effective January 1, 2006. B4185 was added to the HCPCS on January 1, 2006, to replace codes B4184 and B4186 and describes parenteral nutrients (CWF category 20) as opposed to enteral nutrients (CSF category 9).

Per CR4267, the following four adjustable wheelchair cushions codes are added to the HCPCS, effective July 1, 2006:

- **K0734** - Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth
- **K0735** - Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth
- **K0736** - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 Inches, Any Depth.
- **K0737** - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth.

(See the MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4267.pdf> on the CMS web site.)

The fee schedule amounts for the above codes, K0734, K0735, K0736, and K0737, are added to the fee schedule file on July 1, 2006 and are effective for claims submitted with dates of service on or after January 1, 2006.

HCPCS codes A6531 and A6532 were added to the HCPCS January 1, 2006, to replace L8110 and L8120; therefore, all billing and payment requirements for HCPCS codes L8110 and L8120 crosswalk directly to A6531 and A6532, including the requirement to bill modifier AW when items are furnished for use as surgical dressings (see transmittal AB-03-100).

Implementation

The implementation date for the instruction is July 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/R928CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

Durable Medical Equipment Regional Carriers (DMERCs)

DME MAC NEWS #1 - DME Medicare Administrative Contractors' Implementation – Information for Suppliers

Reference: *Medlearn Matters* Number: SE0628

Provider Types Affected

Suppliers that bill Medicare Durable Medical Equipment Regional Carriers (DMERCs) for their services, especially suppliers in the states of **Kentucky, Maryland, Virginia, West Virginia, and the District of Columbia**

Key Points

The Centers for Medicare & Medicaid Services (CMS), in consultation with the current DMERCs, has begun a process to transition work from DMERCs to the new Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) in a way that presents the least disruption to the DME supplier community.

This process will be especially helpful to the suppliers in Kentucky, Maryland, and the District of Columbia, which soon will be serviced by a different Medicare contractor. (See the *Background* section of this article for a brief explanation of why CMS is transitioning to DME MACs.)

The decisions regarding the transition to the DME MACs include the following:

- Two DME MACs (National Heritage Insurance Company, Inc. (NHIC) and AdminaStar Federal) will each assume full responsibility for the work of their respective geographic jurisdiction on July 1, 2006.
- These two new DME MACs have established web pages that will be updated regularly with implementation information, contact numbers, and e-mail addresses. The contractors' web pages are:
 - Ø NHIC: <http://www.medicarenhic.com/dme/index.shtml>
 - Ø AdminaStar: <http://www.adminastar.com/Providers/DMERC/ContractorReform/ContractorReform.html>
- There will be no need for DME suppliers currently enrolled in the Medicare fee-for-service program to re-enroll or obtain a new supplier number. Enrollment information will transfer to the new DME MACs.
- Current EDI Support for each DME region/jurisdiction has been extended until at least September 30, 2006.
- DME MACs will continue to support all DME free billing software packages.
- Although suppliers in Kentucky, Maryland, and the District of Columbia may continue to submit electronic claim transactions to the DME contractor that currently services them and have the claims redirected to the appropriate DME MAC, CMS encourages suppliers to connect to the DME MAC that will service them effective July 1st.
- Connection to the servicing DME MAC will be required to receive all electronic output, including electronic remittance advices.
- Suppliers in Kentucky or those in the states that will be serviced by NHIC must complete a new copy of the Authorization Agreement for Electronic Funds Transfer and submit it to your new DME MAC if you wish to continue to receive Medicare payments via electronic funds transfer (EFT) effective July 1. Please see your DME MAC's web page for specifics.
- Suppliers connected to multiple regions will need to understand regional specific file retrieval options, including how to retrieve remittance advice files.
- Please refer to MLN Matters article SE0540 for more information regarding remittance advice and to MLN Matters article SE0611 for information regarding MREP software you may use to print Medicare's electronic remittances. These articles are available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0540.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf> on the CMS web site.
- New suppliers who want to conduct EDI transactions with Medicare should enroll with the appropriate DME contractor using standard enrollment forms and processes. (Please refer to links below.)

- The implementation of DME MACs for jurisdictions C and D has been delayed pending resolution by CMS of a formal protest of those awards. Because of this delay, suppliers providing services to Medicare beneficiaries in Virginia and West Virginia will continue to be serviced by AdminaStar until further notice. Once the protest is resolved and the new DME MAC for jurisdiction C can be implemented, it will take over the work for Virginia and West Virginia.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) allows CMS to take appropriate steps to transition from contracts under Section 1842(a) of the Social Security Act to contracts with MACs under section 1874A.

The changes to Medicare's administration of the fee-for-service program (Medicare Contracting Reform) are designed to increase the efficiency of Medicare's claim processing and related functions. They will benefit Medicare providers and Medicare's enrollee population.

For more information on Medicare Contracting Reform and plans for the acquisition and implementation of MACS, please see MLN Matters article SE0624 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0624.pdf> on the CMS web site or visit the Medicare Contracting Reform web page on the CMS web site at:

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

On January 6, 2006, CMS announced the following:

- The DME MAC contract for Jurisdiction A (Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) was awarded to National Heritage Insurance Company (NHIC).
- The DME MAC contract for Jurisdiction B (Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin) was awarded to AdminaStar Federal, Inc.
- The DME MAC contract for Jurisdiction C (Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia) was awarded to Palmetto GBA, LLC.
- The DME MAC contract for Jurisdiction D (Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming) was awarded to Noridian Administrative Services.
- A protest of the DME MAC awards for Jurisdictions C and D was filed with the Government Accountability Office (GAO) in January 2006. Until GAO issues a decision (due May 4, 2006) on the protest, any activity associated with the contract awards for administration of MAC Jurisdictions C and D is on hold.

Additional Information

For additional information about Medicare Contracting Reform, and specifically the DME MAC transition process, please refer to the CMS web site at:

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

For information about Medicare Provider-Supplier Enrollment, please refer to the CMS web site at:

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

Form CMS 855S, *Medicare Federal Health Care Provider/Supplier Enrollment Application*, can be found on the CMS web site at:

<http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf>

SE0540, *CMS Releases New Educational Guide on Remittance Advice (RA) Notices*, is located on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0540.pdf>

SE0611, *Medicare Remit Easy Print (MREP) Software*, is available on the CMS web site at:

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

SE0624, *Assignment of Physicians and Providers to the Medicare Administrative Contractors (MACs)*, can be viewed on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0624.pdf>

This last article provides an overview of the Medicare Contracting Reform process as it applies to providers and suppliers.

To find the toll-free telephone number for your Medicare contractor, please refer to the CMS web site at:

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

Changes in the Payment for Oxygen Equipment and Capped Rentals for Durable Medical Equipment (DME) Due to the Deficit Reduction Act (DRA) of 2005

Reference: Trans. 918, CR #5010, Pub. 100-04, Medlearn Matters Number: MM5010

Provider Types Affected

Suppliers and providers billing Medicare durable medical equipment regional carriers (DMERCs) for oxygen equipment/services or other rentals of capped DME. Physicians treating Medicare patients using oxygen equipment or other rentals of capped DME may also want to be aware of this issue.

Background

Recent legislative changes mandated by Section 5101(a) and 5101(b) of the Deficit Reduction Act (DRA) of 2005 require changes to the DME claims processing systems.

The purpose of this article and related CR5010 are to provide DME suppliers with an explanation of how these changes will impact them.

Important Points to Remember

Changes in Capped Rentals for DME

Section 5101(a) of the DRA is effective for capped rental items for which the first rental month occurs on or after January 1, 2006.

- For claims with dates of service (DOS) on and after January 1, 2006, the DMERCs, and eventually their replacements, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), will limit the total number of months for which they make payment for capped rental DME to 13 months.
- After the DME MAC (or DMERC) has paid for 13 months for capped rental DME, title for the equipment will be transferred to the beneficiary.
- This policy applies only to beneficiaries who began a new DME capped rental period for dates of service on or after January 1, 2006.
- For claims with dates of services prior to January 1, 2006, current rules apply.

Changes Related to Payment for Oxygen Equipment:

- Section 5101(b) of the DRA establishes a 36 month (3 year) limit or cap on monthly payments for stationary and portable oxygen equipment. This cap applies to oxygen equipment furnished on or after January 1, 2006, and applies to all claims for the following list of HCPCS codes.

E0424 – Stationary gaseous oxygen system	E0431 – Portable gaseous oxygen system
E0434 – Portable liquid oxygen system	E0439 – Stationary liquid oxygen system
E1390 – Oxygen concentrator, single delivery port	E1391 – Oxygen concentrator, dual delivery port
E1392 – Portable oxygen concentrator	E1405 – Oxygen and water vapor enriching system with heated delivery
E1406 – Oxygen and water vapor enriching system without heated delivery	

- Payments for any of the above described items terminate after a period of continuous use of 36 months beginning on or after January 1, 2006. On the first day after the month for which the 36th monthly payment amount is made, the supplier must transfer title for the stationary and/or portable oxygen equipment to the beneficiary.
- On the same day that title for the equipment is transferred to the patient, **monthly payments can begin to be made for oxygen contents** used with patient-owned gaseous and liquid oxygen equipment.

The HCPCS codes for oxygen contents include the following:

E0441 – Stationary gaseous contents used with patient owned gaseous stationary system	E0442 – Stationary liquid contents used with patient owned liquid stationary system
E0443 – Portable gaseous contents used with patient owned gaseous portable system	E0444 – Portable liquid contents used with patient owned liquid portable system

Note: Medicare DMERCs will begin the 36-month count for beneficiaries that were already receiving oxygen therapy on January 1, 2006. Months prior to January 2006 will not be included in the 36-month count.

- DMERCs will pay for reasonable and necessary maintenance and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of beneficiary-owned equipment (including oxygen concentrators).
- Updates to the *Medicare Claims Processing Manual*, Publication 100-04, and the *Medicare Benefits Policy Manual*, Publication 100-02, related to CR5010 will be made at a later date to reflect these changes.

Use of HCPCS Modifiers

Additional program billing and claims processing instructions will be issued later this year. For now, suppliers should continue to use the KH, KI, and KJ modifiers in the manner as previously instructed for capped rental DME. These modifiers do not need to be submitted for oxygen or oxygen equipment claims. Suppliers should continue to use the BP, BR, and BU modifiers with respect to capped rental periods that began prior to January 1, 2006.

Implementation

The implementation date for this instruction is May 30, 2006.

Additional Information

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

<http://www.cms.hhs.gov/Transmittals/downloads/R918CP.pdf>

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

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

Electronic Data Interchange (EDI)

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 receiving an ERA will continue to get paper remits for 45 days after setup date. However, once this time frame has elapsed, the paper remit mail out will be 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!"

Reminders for Submitting Medicare Provider Numbers Electronically

Reference: LA – FM 051506

For 4010A1 X12 837 claims, when an individual provider number (NOT a clinic or group) is submitted in the 2010AA/REF02 or the 2010AB/REF02, then the 2310B and 2420A loops are not required. When a 2310B or 2420A loop are submitted, a 1C qualifier must be present in the REF01 data element (when the REF is present) to indicate that the Medicare provider number is located in the REF02 data element.

If a clinic or group number is being submitted in the 2010AA or 2010AB (billing provider loops), then a rendering provider number must be submitted in the 2310B/REF02 or 2420A/REF02, with a qualifier of 1C in the REF01.

Ambulatory Surgery Centers (ASC) should also submit their provider number in the 2010AA or 2010AB loop. When an ASC is billing for *physician services*, a rendering provider number is required in the 2310B/REF02 or 2420A/REF02, along with the 1C qualifier in the REF01. However, if an ASC bills for *facility charges* only, a rendering provider number **should not** be submitted in the 2310B/REF02 or 2420A/REF02.

Failure to submit billing/rendering provider numbers correctly may result in denied or rejected claims.

Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More: Options for Providers/Suppliers Affected by CR4376

Reference: Medlearn Matters Number: SE0627

Provider Types Affected

Physicians, suppliers, qualified non-physician practitioners, and other providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Impact to You

This Special Edition reminds providers that as of June 1, 2006, if you have been receiving **both** an Electronic Remittance Advice (ERA), either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a Standard Paper Remittance (SPR) from your carrier/DMERC for 45 days or more, that **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376. This article outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC.

What You Need to Know

Are you receiving an ERA? Make sure you know if and how you receive the ERA. You may be receiving your ERA directly from your carrier/DMERC or you may be receiving your ERA indirectly through a billing agent, clearinghouse, or other entity representing you. No matter how you receive your ERA, if you are also receiving an SPR from your carrier/DMERC in addition to receiving an ERA for 45 days or more, after June 1, 2006, your carrier/DMERC will no longer mail you an SPR. **If you still need both, take appropriate action now.**

What You Need to Do

If you need the SPR, take action **NOW** so you can avoid any business disruption associated with the June 1, 2006, cutoff of the SPR. If your clearinghouse, billing agent, or other entity cannot offer a way (e.g. print software) for you to receive or generate a paper remittance, it may be beneficial to explore other options.

Determine which of the following scenarios represents your situation:

- 1. You are receiving the ERA directly from your carrier in the HIPAA-compliant 835 format:** Use the Medicare Remit Easy Print (MREP) software¹. MREP requires that you import ERAs in the HIPAA-compliant 835 format. (See the *Additional Information* section of this article for further information.) MREP is **free** software that allows you to:
 - Print the ERA for individual or multiple selected claims in a format mirroring the SPR, so you can forward your remittance to secondary/tertiary payers;
 - Easily navigate and view remittance information;
 - Quickly access claim information;
 - Print and export useful reports about ERAs including denied, adjusted, and deductible service lines;
 - Receive the latest version of Claim Adjustment Reason and Remittance Advice Remark Code sets, three times a year;
 - Archive, restore, and delete imported ERAs; and
 - Eliminate physical filing and storage space needs.
- 2. You are receiving a HIPAA-compliant 835 from a billing agent, clearinghouse, or other entity:** Use MREP or software offered by the billing agent, clearinghouse, or other entity representing you to view and print your paper remittance advice.
- 3. You are receiving the ERA directly in a format that is not the HIPAA-compliant 835 format:** Transition to the HIPAA-compliant 835 format now, so you can begin using MREP. CMS ended the

¹ This software was developed by the Centers for Medicare & Medicaid Services (CMS) for use by Medicare providers/suppliers to view and print a Health Insurance Portability and Accountability (HIPAA)-compliant Medicare 835. Medicare has no liability and takes no responsibility for any other use of this software.

contingency plan for non-HIPAA claims, i.e., 837 transaction, in 2005. CMS will be ending the contingency plan for the non-HIPAA remittance advice, i.e., the 835, next.

4. **You are receiving an ERA that is not the HIPAA-compliant 835 format from your billing agent, clearinghouse, or other entity representing you and they do not offer software or other means that allows you to view and print your remittance advice:** Work with them so that they will send you a HIPAA-compliant 835, so you can use MREP.
5. **You have a need for the paper remittance advice and your clearinghouse, billing agent, or other entity representing you is receiving the ERA on your behalf, but does not currently forward the ERA to you:** Work with your clearinghouse, billing agent, or other entity to receive the ERA and use MREP. This may be your situation if the clearinghouse, billing agent, or other entity representing you receives the ERA for you, but until now there has been no business reason to forward the ERA to you.

Background

CMS has an initiative for moving to a more electronic transaction environment and reducing the cost associated with producing and mailing the paper remittances sent by CMS contractors. 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.

Implementation

The implementation date 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

Or, you can view Special Edition MLN Matters article SE0611 at:

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

Or a related MLN Matters article (MM4376) on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.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/>

If you have other 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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

The official instructions (CR4376) 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>

Filing Purchased Services Electronically

Reference: LA – FM 042506

When filing for purchased services, the 2300 AMT01 must contain a qualifier of NE and the amount of the Purchased Service Charge must be submitted in the 2300 AMT02. The Purchased Service Charge Amount must also be entered in the service line 2400 PS102 with the Purchased Service Provider Identifier in the 2400 PS101.

Failure to file purchased services correctly may result in the denial of claims.

Emergency Services

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens: Section 1011 – An Update

Reference: Medlearn Matters Number: SE0633

Provider Types Affected

Physicians, hospitals, and ambulance services that provide emergency health services to undocumented aliens

Impact to You

You may not be receiving funds that are available to you for services you furnish to undocumented aliens, and the Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to inform and/or remind you about these available funds.

What You Need to Know

The Medicare Prescription Drug Improvement and Modernization Act (MMA) (Section 1011) provides \$250 million each year for Fiscal Years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens. You may be eligible to receive some of these funds.

What You Need to Do

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

Background

CMS previously issued MLN Matters Special Edition article SE0535 (MMA – CMS' Implementation of Section 1011 of the Medicare Modernization Act – Federal Funding of Emergency Health Services Furnished to Undocumented Aliens) to inform physicians, hospitals, and ambulance services about the federal funding available to help pay for services furnished to undocumented aliens. See SE0535 on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0535.pdf>

Because some providers may not be utilizing these available funds, CMS is issuing this additional special edition article to inform (and remind) providers about the funds that are available for emergency health services furnished to undocumented aliens.

The MMA (Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens) provides \$250 million each year for Fiscal Years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens:

- Ø Two-thirds of the funds are divided among all 50 states and the District of Columbia, based on their relative percentages of undocumented aliens; and
- Ø One-third of the funds are divided among the six states with the largest number of undocumented alien apprehensions.

Note: Current state allocations of these funds may be viewed on the CMS web site at:

http://www.cms.hhs.gov/UndocAliens/04_state_alloc.asp#TopOfPage

From the respective state allotments, payments are made directly to enrolled hospitals, physicians, and ambulance providers for some or all of the costs of providing emergency health care (required under Section 1867) and related hospital inpatient services, outpatient services, and ambulance services provided to eligible individuals.

As of May 1, 2006, nationally, over 9,000 provider enrollment applications have been approved. The first Section 1011 payment to providers was issued on February 27, 2006, totaling nearly \$25.5 million, and the next quarterly payment to providers will be made on May 29, 2006.

TrailBlazer Health Enterprises, LLC, is the national contractor for the Section 1011 program and is the only contractor for processing all requests for Section 1011 provider payments. So, if you want to request 1011 payments, you must do so by enrolling with TrailBlazer and then submit your requests to TrailBlazer. **Do NOT submit requests for 1011 payment to your regular fiscal intermediary or carrier.** To learn more about the Section 1011 program, or to enroll as a provider, see the TrailBlazer web site at:

<https://www.trailblazerhealth.com/section1011/>

TrailBlazer can also be contacted directly by telephone at (866) 860-1011.

Additional Information

Additional information regarding Section 1011 of the MMA and CMS' policy for the implementation and administration of this program can be found on the CMS web site at:

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

General

Coding of Subsequent Hospital Care

Reference: AR – PAS 042606; May 2004 Provider Newsletter

A nationwide problem of billing levels of subsequent hospital care codes that can not be supported by the patient's condition has been identified. The documentation of the history, Physical exam and Medical Decision Making will support the code billed; however, the extent of the History documented, the extent of the Physical Examination documented and the level of Medical Decision Making are greater than the levels required by the patient's condition. The frequency of these services is usually not an issue, however; all billed services must be based only on activities that are reasonable and necessary for the diagnosis or treatment of illness or injury (SSA 1862(a)(1)(A)).

CPT codes 99231-99233 are used to describe subsequent hospital care. These codes require documentation of the interval history at either problem focused, expanded problem focused, or detailed levels. The examination requires the same levels of documentation. The Medical decision making documentation must support straightforward, low, moderate, or high complexity. The nature of the presenting problem usually **determines** the levels of history and physical exam **required**.

1. CPT code 99231 usually requires documentation to support that the patient is stable, recovering, or improving.
2. CPT code 99232 usually requires documentation to support that the patient is responding inadequately to therapy or has developed a minor complication. Such minor complications might include careful monitoring of co-morbid conditions requiring continuous active management
3. CPT code 99233 usually requires documentation to support that the patient is unstable or has a significant new problem or complication.

Clinical examples of subsequent Hospital care codes are listed below. Please note that the examples were pulled from Appendix C of *CPT 2004*.

It is reasonable to expect higher levels of History and Physical exam to be needed in the days immediately following a hospital admission, following transfer from intensive care, or following an acute exacerbation, complication or de-compensation of the patient's condition(s). It is not expected that these higher levels would be medically necessary when the patient is stable and improving, particularly in the visits on days preceding discharge from the hospital. Documentation of History, Physical Examinations and Medical Decision Making, should not be performed or billed at levels greater than needed for the patient's condition.

Clinical Example:

Coding of the visits during a six-day hospitalization of an eighty year old patient with a presumptive diagnosis of pneumococcal pneumonia and low oxygen saturation.

First day after the day of admission: The patient continues tachypnic with low oxygen saturation, and febrile. The patient is receiving oxygen and broad-spectrum antibiotics awaiting cultures results. At present there is an inadequate response and condition would appear to support the levels of history and Physical exam required for CPT code 99232.

Second day after the day of admission: Less tachypnea, still febrile, still receiving oxygen and broad spectrum –antibiotics. Culture results isolate no specific pathogen and current antibiotics are continued. A continued inadequate response would appear to support the levels of history and Physical exam required for CPT code 99232.

Third day after day of admission: Patient is afebrile, room air oxygen saturation is good. Patient is obviously improved. Current antibiotics continued intravenously for one more day. The patient is recovering and improving. Condition would appear to support the levels of history and Physical exam required for CPT code 99231.

Fourth day after the day of admission: Afebrile with good room air oxygen saturation. IV antibiotics are discontinued and patient started on oral antibiotics. The patient is recovering and improving. Condition would appear to support the levels of history and Physical exam required for CPT code 99231.

Fifth day after day of admission: Patient is discharged and the appropriate discharge code is billed.

Avastin (Bevacizumab) J9035 - Update

Reference: LA – LLC 051106

Avastin is indicated in combination with 5-FU based therapy as first-line treatment of patients with metastatic carcinoma of the colon or rectum, 153.0-153.9 and 154.0-154.9.

Effective September 6, 2005, Avastin is also indicated as a first-line treatment of Non-squamous, non small cell lung cancer, advanced/metastatic, 162.3-162.9, when given in combination with Paclitaxol and Carboplatin. (Prior to May 3, 2006, the effective date for Lung ca was December 14, 2005.)

On May 10, 2006, treatment for Macular Degeneration, 362.52, was approved by the CMDs for Arkansas, Louisiana, Missouri, New Mexico, Oklahoma and Rhode Island with effective date January 1, 2006. Please review the article posted on this web-site entitled “Avastin (Bevacizumab) in the Treatment of Neovascular (Wet) Macular Degeneration” for complete guidance on billing with this diagnosis.

Subsequent Hospital E&M Services Audit

Reference: AR – PAS 042606

Medical Review will continue an on-going service specific audit in Arkansas, Louisiana, Missouri, New Mexico, Oklahoma and Rhode Island for subsequent hospital E&M services (99231-99233). A widespread problem of high utilization has been identified through data analysis, and verified by prepay probe reviews which indicated a high denial rate of CPT codes 99231-99233 due to incorrect coding of the level of service documented. The goal of the on-going audit is to review all levels of subsequent hospital code billing, not limited to one code only and not all codes or all specialties at the same time. Medical Review will be able to educate providers in under- utilization as well as over- utilization of these codes.

Clinical Trial Reminder – Correction

Reference: LA – MKS 042606

Note: This article was originally published in the March 2006 Medicare Provide News on page 39; however it incorrectly identified the below modifier as GV. The correct modifier, which is explained below, should have been QV. We apologize for any confusion this may have caused you or your staff.

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 QV 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.

Consultation vs Referral – What is the Difference?

Reference: OK – LAL 042906

A **consultation** is distinguished from a referral (visit) because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A **referral** is when the referring provider wants to turn the management of the patient over to the other provider. In this case, the “referred to” provider should bill a visit code.

The following must be present when billing for a **consultation**:

- Ø A request for a consultation from an appropriate source and the need for consultation must be documented in the patients medical record
- Ø After the consultation is provided, the consulting physician prepares a written report of his/her findings, which is provided to the referring physician.

The consultation may initiate diagnostic treatments and/or therapeutic services. However, when the consultant assumes responsibility for the patient, consultation codes should no longer be used. Depending on the place of service, the consultant should begin using the appropriate established or subsequent evaluation & management codes.

All claims for consultations (except confirmatory consultations) billed to Medicare must contain the name and UPIN of the referring provider.

Occult Blood Test Number of Services

Reference: OK – WR 050901; August 2001 Provider Newsletter

Note: This article was originally published on page 5 of the August 2001 Medicare Provider Newsletter

Both blood occult feces screening tests (82270 and G0107) include 1-3 simultaneous determinations. Although three specimens are generally collected for these tests, all three specimens are used to complete a single test. Because of this, Medicare will only pay for one blood occult test in a three (3) day period.

CMS Electronic Mailing Lists

Reference: JSM RO 4085-06403, 04-20-06

The CMS Electronic Mailing Lists (list-servs) can help you with your business! For more details, download the Fact Sheet from the following URL: http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf

Health Professional Shortage Area (HPSA)

Revision for Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Bonus Billing for Some Globally Billed Services; Full Replacement for Change Request (CR) 4266

Reference: Trans. 906, CR #5015, Pub. 100-04, Medlearn Matters Number: MM5015

Provider Types Affected

Physicians billing Medicare carriers for the Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) bonus

Provider Action Needed

This article is based on Change Request (CR) 5015, which will allow physicians to submit global services and receive the HPSA and PSA bonuses without having to submit the professional component and technical component (PC/TC) separately.

Background

Currently, components of services with a professional component/technical component of four must be submitted separately in order to receive the HPSA and PSA bonus payments. CR5015 is similar to CR4266 (Transmittal 834) in that it also allows you to submit the global service and receive the bonus payment on all professional component/technical component (PC/TC) 4 codes.

However, CR5015 further instructs that payment is excluded for the following Current Procedural Terminology (CPT) code:

CPT Code 93015 (cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision; with interpretation and report)

Note: The “technical component” of services relates to facilities, equipment, and technical staff required for the delivery of those services, and the “professional component” consists of fees paid to the physician for providing those services. When combined, the “professional and technical” components of a service are referred to as “global” service.

CR5015 instructs that, effective for claims received on or after July 1, 2006:

- When your carrier receives a claim for a service with a PC/TC of 4, **except for CPT Code 93015**; and
- The service is provided in a HPSA or PSA bonus payment area; then
- Your claim will be accepted.

The bonus payment amount is calculated based on the payment amount for the associated professional component code.

Your carrier will make any necessary revision to their systems to be able to calculate the bonus payment just for the professional component of the service. This action will be taken for bonuses paid automatically as well as bonuses paid based on the submission of the QB, QU, AR, or AQ modifiers.

Because there are two associated professional components to 93015, your carrier will follow the instructions in the *Medicare Claims Processing Manual* and **return claims for 93015 as unprocessable**. The services must then be resubmitted as separate components in order to receive the bonus on the appropriate professional component.

Carriers will continue to allow the option of withholding HPSA/PSA bonuses if that is requested by physicians and the carriers will not pay the bonus on PCTC 4 to physicians who have already notified them of their decision to not receive HPSA/PSA bonuses.

Note: CR5015 does not affect current HPSA or PSA payment policy.

Implementation

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

Additional Information

The revised *Medicare Claims Processing Manual* - Publication 100.4, Chapter 12 (Physician Practitioner Billing), Section 90.4.5 (Services Eligible for HPSA and Physician Scarcity Bonus Payments), is attached to CR5015, which is the official instruction issued to your carrier regarding this change. That instruction may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R906CP.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/>

Independent Diagnostic Testing Facility (IDTF)

Independent Diagnostic Testing Facility (IDTF) Claims

Reference: LA – FM 051506

IDTF claims submitted electronically should not be filed with a rendering provider number in the 2310B REF02 or 2420A REF02. IDTF provider numbers do not have providers linked to them, and as a result, should not be filed this way. The billing provider number should be submitted in the 2010AA or 2010AB loop. The 2310B or 2420A loops can be repeated, but the 1C qualifier must be submitted again in the REF01 and the billing provider number repeated in the REF02 of those loops.

IDTF claims may be denied if the provider number is not submitted correctly.

Mammography Services

Correct Reporting of Diagnosis Codes on Screening Mammography Claims

Reference: Trans. 916, CR #5050, Pub. 100-04, Medlearn Matters Number: MM5050

Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

Providers Action Needed

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

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain **ONLY SCREENING** mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain **OTHER** services in addition to a screening mammography.

In addition, CR5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It **removes 12X type of bill (TOB)** from the list of applicable TOBs for diagnostic mammography;
- It **adds HCPCS code G0202** to the list of valid codes for the billing of screening mammography; and
- It **adds HCPCS codes G0204 and G0206** to the list of valid codes for the billing of diagnostic mammographies.

Background

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

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

Implementation

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

Additional Information

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

<http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf>

The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR5050.

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

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

Medicare Administrative Contractors (MACs)

Assignment of Physicians, Providers, and Suppliers to the Medicare Administrative Contractors (MACs)

Reference: Medlearn Matters Number: SE0624

Provider Types Affected

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

Key Points

The Centers for Medicare & Medicaid Services (CMS) is implementing significant changes to the Medicare fee-for-service program's administrative structure. This Medicare Contracting Reform (MCR) will:

- Integrate and simplify the administration of Medicare Parts A and B with primary A/B MACs which will process both Part A and Part B claims for the fee-for-service benefit;
- Make contracting dynamic, competitive and performance-based, resulting in more accurate claims payments and greater consistency in payment decisions; and
- Centralize information, creating a platform for advances in the delivery of comprehensive care.

Under MCR, there will be 23 Medicare Administrative Contractors (MACs) with no national MAC. These new MACs will include:

- Fifteen primary A/B MACs to serve the majority of all types of providers for Part A and Part B;
- Four specialty MACs to serve home health and hospice providers; and
- Four specialty MACs to serve durable medical equipment (DME) suppliers.

MACs will serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements training for providers, and the receipt, processing and payment of Medicare fee-for-service claims for Medicare providers' respective jurisdictions.

Medicare providers will be assigned to the local designated MAC based on their geographic location to the MAC which has jurisdiction for that benefit category and location.

Note: Please be aware that in the event that your current FI does not win the contract to serve the area where you are located, you will be required to be reassigned to the MAC that has won the jurisdiction for your area.

The new MAC jurisdictions will be more similar to each other in size than the existing fiscal intermediary (FI) and carrier jurisdictions. The workload allocation and the number of fee-for-service beneficiaries and providers in each MAC jurisdiction will be reasonably balanced. The jurisdictions of the eight specialty MACs will overlay the boundaries of the fifteen primary A/B MAC jurisdictions.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) allows the CMS to take appropriate steps to transition from agreements under Section 1816 of the Social Security Act to contracts with Medicare Administrative Contractors (MACs) under section 1874A. The changes to Medicare's administration are designed to increase the efficiency of Medicare's claims processing and related functions. They will benefit Medicare providers and Medicare's enrollee population.

Additional Information

During the initial implementation phase (2005-2011) of the Medicare fee-for-service administrative contracting reform, CMS intends to issue Requests for Proposals (RFPs) to compete and award contracts for 23 MACs (four DME and four Home Health/Hospice MACs, and 15 primary A/B MACs).

The transition to the MAC administrative structure will be implemented through a series of acquisition cycles (9-12 months from solicitation to award). The subsequent workload transition to the new MAC system is projected to take 6-13 months after contract award.

Medicare's MAC Jurisdictions

Jurisdiction	States Included in Jurisdiction	Procurement Schedule	
		RFP Issuance	Award Date
	Specialty MAC Jurisdictions (DME and Home Health/Hospice)		
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont	DME March 2005	DME Jan. 2006
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin		
C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia	Home Health/ Hospice Sept. 2007	Home Health/ Hospice Sept. 2008
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming		
Jurisdiction	Primary A/B MAC Jurisdictions	RFP Issuance	Award Date
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands	Sept. 2006	Sept. 2007
2	Alaska, Idaho, Oregon, and Washington	Sept. 2006	Sept. 2007
3	Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming	Sept. 2005	June 2006
4	Colorado, New Mexico, Oklahoma, and Texas	Sept. 2006	Sept. 2007
5	Iowa, Kansas, Missouri, and Nebraska	Sept. 2006	Sept. 2007
6	Illinois, Minnesota, and Wisconsin	Sept. 2007	Sept. 2008
7	Arkansas, Louisiana, and Mississippi	Sept. 2006	Sept. 2007
8	Indiana and Michigan	Sept. 2007	Sept. 2008
9	Florida, Puerto Rico, and U.S. Virgin Islands	Sept. 2007	Sept. 2008
10	Alabama, Georgia, and Tennessee	Sept. 2007	Sept. 2008
11	North Carolina, South Carolina, Virginia and West Virginia	Sept. 2007	Sept. 2008
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania	Sept. 2006	Sept. 2007
13	Connecticut and New York	Sept. 2006	Sept. 2007
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	Sept. 2007	Sept. 2008
15	Kentucky and Ohio	Sept. 2007	Sept. 2008

For additional information about the MCR process, please refer to the CMS web site at:

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

CR4002, transmittal 670, Realignment of States and Medicare Claims Processing Workload from DMERC Regions A, B, C and D to the DME MAC Jurisdictions A, B, C, and D discusses phase 1 of the MAC acquisition and transition schedule. It can be found on the CMS web site at:

<http://www.cms.hhs.gov/transmittals/downloads/R670CP.pdf>

Medicare Secondary Payer (MSP)

New Medicare Secondary Payer Balancing Edits

Reference: AR – KDA 0518006; CR4261

Effective July 3, 2006, inbound Medicare Secondary Payer (MSP) claims will be rejected if the paid amounts and the adjusted amounts paid by the primary payer do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify adjustments performed.

New pre-pass edits M383 and M384 have been created to reject MSP claims if the paid amounts and the adjusted amounts do not equal the billed amounts at the line level.

For all 2430 loops, the following loops/data elements must equal the Submitted Charges in the 2400/SV102 or the claim will reject with edit M383:

$2430/CAS03 + 2430/CAS06 + 2430/CAS09 + 2430/CAS12 + 2430CAS15 + 2430CAS18$

If the 2320/AMT01 = D – then the following loops/data elements must equal the Total Claim Charges in the 2300/CLM02 or the claim will be rejected with pre-pass edit M384:

$2320/AMT02 + 2320/CAS03 + 2320/CAS06 + 2320/CAS09 + 2320/CAS12 + 2320/CAS15 + 2320/CAS18 + 2430/CAS03 + 2430/CAS06 + 2430/CAS09 + 2430/CAS09 + 2430/CAS12 + 2430/CAS15 + 2430/CAS18$

Edits M385 and M386 were created to reject claims lacking the standard claim adjustment reason codes to identify the adjustment performed. The following will apply to all 2430 and 2320 loops: A valid standard reason code will be required in the CAS02, 05, 08, 11, 14 & 17 when reductions/adjustments are submitted in the CAS03, 06, 09, 12, 15 & 18. (Examples: If 2430/CAS03 is numeric and does not equal zero (0), then 2430/CAS02 must contain a valid standard claim adjustment reason code or the claim will reject with edit M385. If 2320/CAS03 is numeric and does not equal zero (0), then 2320/CAS02 must contain a valid standard claim adjustment reason code or the claim will reject with edit M386.)

Current pre-pass edits M208 – M213 and M243 - M248 will be deleted effective July 3, 2006 to allow for negative values in CAS Adjustment Amount fields.

Medicare Summary Notice (MSN)

Quarterly Medicare Summary Notice (MSN) Printing Cycle

Reference: Trans. 945, CR #5062, Pub. 100-04, Medlearn Matters Number: MM5062

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries

Impact on Providers

This article is based on Change Request (CR) 5062, which instructs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) to print and mail No-Pay Medicare Summary Notices (MSNs) on a quarterly schedule (rather than the current monthly schedule).

Background

Current Centers for Medicare & Medicaid Services (CMS) instructions require all Medicare contractors to issue a MSN to each beneficiary for whom a claim was processed during the last 30 days (possibly for services received more than 30 days ago) to inform the beneficiary of the disposition of all claims (i.e., a record of services received, the status of any deductibles, and appeal rights).

In an effort to reduce overall operating costs, CR5062 instructs your intermediary/carrier to change from their current monthly (30 day) No-Pay MSN mailing schedule to a quarterly (90 day) No-Pay MSN mailing schedule. All MSN information should continue to print; however, summations will occur on a quarterly basis as opposed to a monthly basis.

No-Pay MSNs are the standard, system-generated MSNs produced for beneficiaries in which Medicare did not issue payment to the beneficiary for the respective claim. Beneficiaries often need these MSNs in order to obtain payment from another payer/insurer.

In those situations where a No-Pay MSN is needed or lost by a beneficiary, they can request a No-Pay MSN by calling 1-800 Medicare. On-demand requests will be generated and mailed once the request is made.

In summary, CR5062 provides the following instructions:

- Beginning no later than October 1, 2006, Medicare contractors will issue No-Pay MSNs on a quarterly/90-day mailing cycle as opposed to the previous monthly/30-day mailing cycle;
- MSNs with checks will continue to be mailed out as processed; and
- If a beneficiary requests a monthly No-Pay MSN (as opposed to the quarterly MSN), then Medicare contractors must generate and mail out the MSN at the time of the request.

Implementation

The implementation date for the instruction is June 12, 2006, for carriers, July 1, 2006, for DMERCs, and September 1, 2006 for FIs.

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/R945CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

National Provider Identifier (NPI)

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

Reference: CR 4023; LA – FFM040706

During Stage 2 (to begin October 1, 2006 and end on May 22, 2007) of the implementation of the NPI, NPIs will be accepted on claims and other EDI transactions, in DDE screens, and paper claims (once the revised Form CMS-1500 transition periods begin). The NPIs will be reported on X12 277 and 837 coordination of benefit (COB) outbound transactions if reported on the corresponding inbound transactions. The NPIs will be reported in X12 835 version 4010A1 transactions and standard paper remittance (SPR) letters when the pay-to-provider's NPI is in the data center provider file, and NPIs will be retained in claims history in addition to a provider's Medicare legacy identifier.

Submitters of X12 837, (including claims submitted via MCE software) and DDE claims should continue to submit the Medicare provider legacy identifier of each provider for which information is reported in a transaction, in addition to a provider's NPI, once available, during Stage 2. Failure to report a legacy identifier for a provider when an NPI is reported for that provider could delay processing of a claim.

Submitters of X12 276 should also report the corresponding Medicare provider legacy number in a repeat of the 2100C loop when submitting an NPI in the 276 claim status request. Failure to report both numbers could result in rejection or delay in processing of your query.

Medicare provider legacy identifiers should continue to be reported in any inbound non-HIPAA electronic transaction for which the Medicare HIPAA contingency plan will not yet have been terminated by October 1, 2006. Reporting of NPIs in those non-HIPAA formats will result in rejection or incorrect processing of those transactions.

NPIs will be used to identify a provider for which an 835 remittance advice transaction is generated when the NPI is available in CMS files, on or after the start of Stage 2. The provider's legacy identifier will continue to be reported in those 835s during Stage 2.

Medicare Remit Easy Print (MREP) users are to cease use of prior versions of this software once the version is available that is able to print the provider's NPI as well as the provider's legacy identifier. Once available, you may obtain the updated version of MREP software by contacting Arkansas EDI Services at 866-582-3247.

Effective October 1, 2006 pre-pass edit M360 will be created to validate the Carrier Number received on the file in the 1000B NM109. Files without a valid Carrier Number in the 1000B NM109 (Receiver Primary Identifier) will be rejected. Carrier Numbers for each state are identified below:

Arkansas Medicare Part B ----- 00520
New Mexico Medicare Part B ----- 00521
Oklahoma Medicare Part B ----- 00522
Missouri Medicare Part B ----- 00523
Rhode Island Medicare Part B ----- 00524
Louisiana Medicare Part B ----- 00528

All of the following pre-pass edits are currently set to issue an informational message on the Batch Detail Control Listing (H99) report. The actual effective date that rejections will begin will be no later than October 1, 2006.

The following new pre-pass edits will reject claims for EIN (Employer Identification Number) or SSN (Social Security Number) when not formatted as EIN or SSN. If the REF01 (in the applicable loops below) equals SY (for SSN), then REF02 must be a 9 byte numeric and in format NNNNNNNNNN, NNN(space)NN(space)NNNN or NNN-NN-NNNN. If the REF01 (in the applicable loops) equals EI (for EIN), then REF02 must be a 9 byte numeric and in format NNNNNNNNNN, NN-NNNNNNNN or NN(space)NNNNNNNN.

<u>Edit Number</u>	<u>Loop</u>
M362	2010AA
M363	2010AB
M364	2310A
M365	2310B
M366	2310C
M367	2310E
M373	2420A
M374	2420B
M375	2420D
M376	2420E
M377	2420F

The following new pre-pass edits will reject claims for EIN when not formatted for EIN. If the REF01 (in the applicable loops) equals EI (for EIN), then REF02 must be a 9 byte numeric and in format NNNNNNNNN, NN-NNNNNNN or NN(space)NNNNNNN.

<u>Edit Number</u>	<u>Loop</u>
M368	2330D
M369	2330E
M370	2330F
M372	2330H

The following new pre-pass edits will reject claims for Federal Taxpayer's Identification Number when not formatted for Federal Tax ID. If the REF01 (in the applicable loops) equals TJ (Federal Taxpayer's Identification Number) the REF02 must be a 9 byte numeric and in format NNNNNNNNN, NNN(space)NN(space)NNNN, NNN-NN-NNNN, NN-NNNNNNN, or NN(space)NNNNNNN.

<u>Edit Number</u>	<u>Loop</u>
M371	2420C
M378	2310D

Latest National Provider Identifier (NPI) News

Reference: CMS List-Serv Message 042806

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

CMS has released three new educational products on the National Provider Identifier (NPI):

- Ø **"Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees" Tip Sheet**-- Contains helpful information for organization health care providers who wish to apply for NPIs, or submit updates using the NPPES web-based process, on behalf of their employed health care providers. This is NOT the EFI process.
- Ø **"Tips for Health Care Professionals - Preparing Your Office Staff for NPI" Tip Sheet** - Provides basic steps to prepare your office staff, and your business, for NPI implementation.
- Ø **"NPI Overview" PowerPoint Presentation** - This presentation was presented by a CMS staff member at a recent WEDI meeting and contains basic information on the NPI that is suitable for self education, as well as training purposes.

To view these new products, visit the Educational Resources page on CMS' NPI website at:

http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp

National Provider Identifier (NPI) Information about Electronic File Interchange (EFI)

Reference: CMS List-Serv Message 050106

Beginning May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) announced the capability for health industry organizations to submit health care providers' applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider's NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format.

EFI is an alternative to health care providers having to apply for their NPIs via the web-based or paper application process. After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers. Interested health industry organizations should avail themselves of the EFI materials available from the CMS NPI page (<http://www.cms.hhs.gov/NationalProvIdentStand/>) and from the NPPES page (<https://nppes.cms.hhs.gov>) before downloading and completing the Certification Statement (available at <https://nppes.cms.hhs.gov>) and registering as EFI Organizations. A completed Certification Statement must be approved by CMS before an interested health industry organization can participate in EFI.

Prescription Drug Coverage

Coverage of Prescription Niacin Products under Part D for 2006

Reference: Medlearn Matters Number: SE0626

Provider Types Affected

Physicians and other providers who prescribe medications for Medicare patients under Medicare Part D

Key Points

- Ø On April 11, 2006, the Centers for Medicare & Medicaid Services (CMS) informed Medicare Part D prescription drug coverage plans, via a memorandum titled “**CMS Clarification of Coverage of Prescription Niacin Under Part D**,” that was issued over the Health Plan Management System (HPMS), that prescription Niacin products (Niaspan®, Niacor®) can be a covered Part D drug for treatment of dyslipidemic therapy and may be included on Medicare prescription drug plan formularies. Medicare prescription drug plans have the option of covering those drugs immediately.
- Ø For the remainder of contract year 2006, Medicare Part D plans may put prescription Niacin products (Niaspan®, Niacor®) on their formularies, but they are not required to do so. As a result, enrollees may obtain coverage of prescription Niacin products either as a formulary drug or as a non-formulary drug through the exceptions process.
- Ø For contract year 2007, prescription Niacin products (e.g., Niaspan® and Niacor®) used at dosages much higher than appropriate for nutritional supplementation should be considered for formulary inclusion similar to all other Medicare Part D drugs.
- Ø Please refer to the *Additional Information* section of this Special Edition article for specific information regarding two methods for Part D Medicare beneficiary enrollees to obtain prescription Niacin products for the remainder of 2006

Background

The prescription Niacin products are used therapeutically for the treatment of dyslipidemia at much higher dosages than are appropriate for nutritional supplementation. They do not serve as a nutritional supplement or to address a vitamin deficiency. For these reasons, CMS has decided that prescription Niacin products should not be considered a prescription vitamin for purposes of Medicare Part D coverage.

Prescription Niacin products are not universally excluded from coverage under the Medicare prescription drug program. This reverses an earlier February 3, 2006 decision by CMS that prescription Niacin products (Niaspan®, Niacor®) are prescription vitamins and therefore are excluded from the definition of a Medicare Part D drug under the statute.

Additional Information

Prescribing Prescription Niacin products (Niaspan®, Niacor®) for the Remainder of 2006

For Medicare beneficiaries in plans that INCLUDE prescription Niacin products on their formulary:

- Ø If prescription Niacin products **are not subject** to prior authorization – a Medicare prescriber writes a prescription for the prescription Niacin product and the Part D enrollee has the prescription filled at a local retail pharmacy or a mail order pharmacy. If the enrollee is a resident of a long term care facility, the prescription will be filled by the long term care pharmacy serving that facility.
- Ø If prescription Niacin products **are subject** to prior authorization—the Medicare prescriber must file a prior authorization request on behalf of the enrollee. Each Medicare Part D plan has its own form, available on the plans’ web sites (some plans have specific forms for particular drugs; others use a standard prior authorization form).
- Ø Plans must approve or inform the enrollee why they have disapproved a prior authorization request within 72 hours. An enrollee or an enrollee’s physician can request an “expedited coverage determination” for a decision within 24 hours if the enrollee’s health, life, or ability to regain maximum function may be seriously jeopardized by waiting 72 hours for a decision.
- Ø If a Medicare Part D plan disapproves a prior authorization request (i.e., makes an “adverse coverage determination”), the enrollee has the right to request a redetermination from the plan sponsor (see below).

For plans that **do not** have prescription Niacin products (Niaspan®, Niacor®) on their formularies:

- Ø If a Medicare beneficiary is currently taking a prescription Niacin product and is enrolled in a Medicare Part D plan that does not include prescription Niacin products on its formulary, the beneficiary can now ask for an exception to get coverage for a prescription Niacin product (see below).
- Ø If a Medicare beneficiary who is currently taking a prescription Niacin product enrolls in a Medicare Part D plan that does not include prescription Niacin products on its formulary, the plan is required to have a process to ensure the enrollee's smooth transition into the plan and to allow the enrollee time to obtain medically necessary exceptions to the plan's formulary.
- Ø Many Medicare Part D plans have adopted a "first fill" policy that will allow enrollees to have their first prescription for the prescription Niacin product filled even if prescription Niacin products are not on the plan's formulary. This will allow Medicare beneficiaries who have been stabilized on a prescription Niacin product to continue taking it while they request exceptions.
- Ø The transition process is a very temporary solution, however, and enrollees and providers should not delay pursuing exceptions. Prescribers may advise enrollees to contact their plans for more information about their plan's transition process.

Exceptions and Appeals

If a physician prescribes a non-formulary drug for an enrollee, the enrollee or physician must request an exception, which is a type of coverage determination, to obtain the non-formulary drug for the enrollee. If the plan sponsor's coverage determination is unfavorable, the enrollee may appeal the plan sponsor's decision.

Exceptions

An enrollee or an enrollee's physician has the right to request an **exception** for coverage of non-formulary prescription Niacin products. The enrollee's prescribing physician should submit a statement supporting the exception request. The Part D plan must notify the enrollee of its decision within 72 hours after receiving the physician's supporting statement. If the enrollee or physician requests an expedited decision, the plan sponsor must notify the enrollee of its decision within 24 hours after receiving the physician's supporting statement if the plan determines, or the enrollee's physician indicates, that applying the 72-hour timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

The plan must grant the exception if it determines that the requested drug is medically necessary, consistent with the physician's statement. The Medicare provider physician's statement must state that the exception is medically necessary to treat the Medicare beneficiary enrollee's disease or medical condition because all of the covered Medicare Part D drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective as prescription Niacin products, would have adverse effects, or both.

Appeals

If a plan sponsor issues an adverse coverage determination, the decision may be appealed. There are five successive levels of appeal.

- Ø If a plan sponsor issues an unfavorable coverage determination, the enrollee has the right to request a standard or expedited **redetermination** with the plan sponsor within 60 calendar days from the date of the notice of the plan sponsor's adverse coverage determination. Enrollees or their prescribing physician can submit written evidence and legal arguments for coverage of prescription Niacin products during the redetermination process. The plan sponsor must notify the enrollee of its decision within 7 calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- Ø If the plan sponsor's redetermination decision is unfavorable, the enrollee has the right to request **reconsideration** by the independent review entity (IRE) that contracts with CMS. This request must be submitted in writing within 60 calendar days from the date of the notice of the plan sponsor's adverse redetermination decision. The IRE must solicit the views of the prescribing physician orally or in writing and must notify the enrollee of its decision within 7 calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- Ø If the IRE denies the request for coverage and the amount remaining in controversy is at least \$110, the Medicare beneficiary enrollee has the right to request a **hearing before an Administrative Law Judge (ALJ)**. The request must be filed in writing within 60 calendar days from the date of the notice of the IRE's adverse reconsideration determination.

- Ø If the ALJ's decision is unfavorable, the enrollee has the right to request a review by the **Medicare Appeals Council**. The request must be filed in writing within 60 calendar days from the date of the notice of the ALJ's adverse decision.
- Ø If the MAC issues an adverse decision, the enrollee has the right to request judicial review of the ALJ's decision by **filing a civil action in U.S. District Court** if the amount remaining in controversy is at least \$1,090. The request must be filed in writing within 60 calendar days from the date of the notice of the MAC's adverse decision.

For additional information, CMS has a number of MLN Matters special edition articles on the new drug program, especially the fourth and fifth articles in the MLN Matters series about Medicare's new prescription drug coverage.

SE0537, *New Educational Products Available*, is the fourth article in the series and can be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0537.pdf>

SE0541, *More Web-based Educational Products Available on Medicare Prescription Drug Coverage*, is the fifth article in the series. It is available on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0541.pdf>

Preventive Services

Medicare Provides Coverage for Many Preventive Services and Screenings

Reference: *Medlearn Matters* Number: SE0630

Provider Types Affected

All Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who provide and bill for preventive services and screenings provided to Medicare beneficiaries.

Provider Action Needed

This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

Introduction

Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This Special Edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services.

Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Ø Adult Immunizations
 - Influenza (Flu)
 - Pneumococcal Polysaccharide Vaccine (PPV)
 - Hepatitis B Virus (HBV)
- Ø Bone Mass Measurements
- Ø Cancer Screenings
 - Breast (Mammography)
 - Cervical & Vaginal (Pap Test & Pelvic Exam)
 - Colorectal
 - Prostate
- Ø Cardiovascular Disease Screening
- Ø Diabetes Screening, and
 - Self-Management Training
 - Medical Nutrition Therapy
 - Supplies
- Ø Glaucoma Screening
- Ø Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Ø Smoking and Tobacco-Use Cessation Counseling Services

CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

Educational Products and Informational Resources for Health Care Professionals

CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare's coverage of disease prevention and early detection;
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible; and
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

Product Ordering Instructions

To order a product, free of charge, click here: [Order Product](#).

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of tri-fold brochures provides an overview of Medicare's coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See *Expanded Benefits* brochure)

- *Adult Immunizations* http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization_06-08-05.pdf
- *Bone Mass Measurements* http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.pdf
- *Cancer Screenings* http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening_06-08-05.pdf
- *Expanded Benefits* http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits_06-08-05.pdf
- *Glaucoma Screening* http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma_06-08-05.pdf
- *Smoking and Tobacco-Use Cessation Counseling Services*
<http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf>

Guides

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals - This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005; See the Errata Sheet for corrections identified since May 2005 printing.) http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services - This guide provides information on interpreting the Medicare beneficiary preventive services "next eligible date" data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access Common Working File (CWF) records. (September 2005; Available in download only) http://www.cms.hhs.gov/MLNProducts/downloads/Preventive_Services_Eligibility.pdf

Medicare Preventive Services CD ROM

Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals - This CD ROM contains *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*; six brochures: 1) *Expanded Benefits*, 2) *Glaucoma Screenings*, 3) *Cancer Screenings*, 4) *Bone Mass Measurements*, 5) *Adult Immunizations*, and 6) *Smoking and Tobacco-Use Cessation Counseling Services*; and a *Quick Reference Information: Medicare Preventive Services* chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. (See Errata Sheets for corrections identified since May 2005 printing of these products; See product ordering instructions above.)

Quick Reference Information Chart

Quick Reference Information: Medicare Preventive Services - This two-sided laminated chart gives a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (May 2005; See Errata Sheet for corrections identified since May 2005 printing.)

http://www.cms.hhs.gov/MLNProducts/downloads/qr_prevent_serv.pdf

Video Programs

Flu Billing Made Easy - This video explains the process of billing for flu and pneumonia vaccinations. (January 2004) (English and Spanish) Ordering and other relevant information can be found at the following web pages:

- *Flu Billing Made Easier – Order (English and Spanish video)*
http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5
- *Flu Billing Made Easier – Video Transcript*
<http://www.cms.hhs.gov/MLNProducts/Downloads/FluBillingMadeEasierTranscriptNOV05.pdf>
- *Flu Billing Made Easier – Video Errata*
<http://www.cms.hhs.gov/MLNProducts/downloads/downloads/ErrataFluBillingNOV05.pdf>
- *Flu Billing Made Easier Recommended Dial-Up*
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf>
- *Flu Billing Made Easier Recommended DSL/Cable*
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf>
- *Flu Billing Made Easier Recommended T1/DS3*
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf>

Web-Based Training Courses

Web-Based Training Modules (WBTs) - Three web-based training courses covering coding, billing, coverage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products web page at <http://www.cms.hhs.gov/MLNProducts/>, scroll to the bottom of the page to “Links Inside CMS” and click on Web-based Training Modules.

Web Page

MLN Preventive Services Web Page - This Medicare Learning Network (MLN) web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article.

Other Useful Provider Resources

Other useful provider resources include the following:

Prevention Toolkit - This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits.

Immunizations Toolkit - This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers.

CMS Prevention Web Pages

CMS has created individual web pages for each of the preventive services and screenings covered by Medicare. For additional information visit <http://www.cms.hhs.gov/home/medicare.asp> and scroll down to the Prevention section.

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

We encourage you to order and use these provider-specific products to:

- Increase your awareness of preventive services covered by Medicare;
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits; and
- Help you file preventive services claims more effectively.

Please Note: These products have been developed for you, the health care professional. Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

Preventive Benefit Information for Medicare Beneficiaries

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

Provider Enrollment

Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications

Reference: Medlearn Matters Number: SE0632

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

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

Enhancements

- Ø Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language;
- Ø Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application;
- Ø Added tips on how to avoid delays in the enrollment process; and
- Ø Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

Significant Changes

- Ø Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application;
- Ø Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information; and,
- Ø Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

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

- Ø A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS 855I form. In the past, such suppliers had to complete the CMS 855B, CMS 855I and CMS 855R. However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

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

- Ø Removed the requirement to collect crew member and certain vehicle information from ambulance companies **in Attachment 1 of the application.**
- Ø Revised the Independent Diagnostic Testing Facility information contained in Attachment 2 of the application.

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

- Ø Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d) (2) (B) of the Medicare Modernization Act. See MLN Matters article SE0582 on the CMS web site at:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf>

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.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf>

Facilitating Your Medicare Enrollment

Reference: Medlearn Matters Number: SE0634

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Key Points

This Special Edition provides additional information regarding the submission of a Medicare enrollment application.

All Provider Enrollment Applications

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. In addition to providing the documentation previously required, all applicants are required to:

- Ø Submit their National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and
- Ø Complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

Contractor Request for Additional Information

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.

Applications Received Through June 2, 2006

Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPPES. In addition, providers and suppliers who choose to use the 11/2001 version of the 855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes.

Specifically, Section 1 must be completed by Physician Assistants and providers' reassigning all of their benefits, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare Identification Number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4.

Applications Received On or After June 5, 2006

All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-588.

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.

Special Edition article SE0612 and SE0632 contain helpful information about the Medicare enrollment process. You may review the article on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf>; and

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf>.

Remittance Advice

Medicare Remit Easy Print (MREP) Update

Reference: Trans. 927, CR #5032, Pub. 100-04, Medlearn Matters Number: MM5032

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), for services provided to Medicare beneficiaries.

Impact to You

This article is based on Change Request (CR) 5032 which advises providers to use Medicare Remit Easy Print (MREP) software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (RA) for accounts reconciliation and crossover claims submission to secondary/tertiary payers.

What You Need to Know

CR5032 also includes instructions for Medicare's system maintainer (VIPS) to update MREP software with additional functionalities, and directs carriers and DMERCs to test and communicate to the end users about the software update.

What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) developed Medicare Remit Easy Print (MREP) software as a tool providers can use to read and print an electronic remittance advice (RA) in a human readable format. The format is based on the current Standard Paper Remittance (SPR) format. Providers who use the MREP software package can:

- Print paper documentation that can be used to reconcile accounts receivable; and
- Create document(s) that can be included with claim submissions to Coordination of Benefits (COB) payers.

The MREP software became available on October 11, 2005, to providers (Part B and DMERC) through their respective Medicare carrier/DMERC, and it was updated this year in April and July.

CR5032 further encourages providers to use the MREP software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic RA for accounts reconciliation and crossover claims submissions to secondary/tertiary payers.

CMS created a process to receive suggestions from providers, Medicare Contractors, and CMS staff in order to continuously improve and enhance MREP's functionality and effectiveness. A summary listing of the improvements to be implemented in the October 2006, update of MREP is included in the *Additional Information* section of this article.

Note: This update to MREP software includes suggestions for improvements received before the cut off date of March 15, 2006.

Beginning June 1, 2006, Medicare contractors and DMERCs (and later DMACs) will start suppressing the issuance of standard paper remittance advices (SPRs) to providers/suppliers, billing agents, clearing houses, or other entities representing providers, who also have been receiving electronic remittance advice (ERA) transactions for 45 days or more. MREP is an option for providers to print their own remittances at their own computer.

After the October 2006 update, annual updates of MREP will be provided every October unless a critical error affecting production needs to be corrected. The software will also be updated three times a year to implement the Claim Adjustment Reason and Remittance Advice Remark code changes.

See Special Edition MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf> on the CMS web site for options for providers affected by this change.

Implementation

The implementation date for CR5032 is October 2, 2006. Your carrier/DMERC will post a notice to their web site on or after October 2, 2006, to alert you that the new version of the MREP software is available for download and that the software includes the latest version of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R927CP.pdf> on the CMS web site.

If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

List of Improvements to be Implemented in October 2006

Synopsis of Change
A provider would like to have the Provider ID added after the Payee Name. This way, when they have multiple providers and provider locations, they can sort them easier. The Provider ID will be displayed after the Payee Name on the MREP Main Page.
New report/listing of accounts NOT FORWARDED to supplemental or crossovers.
A new report is added to show "Late Filing."
A new report will be created showing only those items with coinsurance.
Print reason/remark codes on same page as Remittance; or, can there be a check box that will either print the codes or not? The MREP software is being changed to include a check box to allow the user to have the remit print with or without the reason/remark codes.
The program should automatically import the 835 file. CMS is looking into this possibility or identifying and displaying the 835 file and path.
Searchable "Help" menu and Index. The analysis is underway to determine the appropriate level of a help facility.

Remittance Advice Initiative

Reference: JSM CI 3898-06422, 05-01-06

"Medicare Remit Easy Print (MREP) Version 1.7 is now available for download! Version 1.7 includes the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as fixes for importing 835 files. These fixes help you specifically identify any problems encountered while importing your 835 with an Import Exception Summary report! In addition, there are some documentation changes to the User Guide. Remember you can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software now available to view and print the HIPAA compliant 835! In order to use the latest version of MREP (Version 1.7), you must click on the link and download the software in its entirety at:

- Arkansas:** <http://www.arkmedicare.com/provider/edi/software/default.htm>
- Louisiana:** <http://www.lamedicare.com/provider/edi/software/default.htm>
- Missouri:** <http://www.momedicare.com/provider/edi/software/default.htm>
- Oklahoma/New Mexico:** <http://www.oknmmedicare.com/provider/edi/software/default.htm>
- Rhode Island:** <http://www.rimedicare.com/provider/edi/software/default.htm>

Remittance Advice Education Guide on CD-ROM

Reference: CMS List-Serv Message 050306

The Medicare Learning Network is pleased to announce that Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers is now available on CD-ROM. Copies of this CD-ROM may be ordered, free of charge, through the Medicare Learning Network's (MLN) Product Ordering Page located on the CMS web site at:

http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5

This publication may also be downloaded and viewed online at the following url <http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=remit&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061410> on the MLN Publications page. The web version of the "RA Guide" may be reprinted or redistributed as needed. Hard copies of the "RA Guide" will be available later this Spring.

Therapy Services

Changes Conforming to Change Request 3648 (CR3648) for Therapy Services

Reference: Trans. 941 and 55, CR #4014, Pub. 100-04 and 100-03, Medlearn Matters Number: MM4014

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 therapy services

Impact to You

This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term “speech therapy” to “speech-language pathology.”

What You Need to Know

To conform to changes in CR3648, CR4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist. Requirements for therapy services incident to a physician have not been changed.

What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: the term “speech therapy” is being changed to “speech-language pathology.”

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR3648 can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>

Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer’s adjudication process:

- Date last seen; and
- The Unique Provider Identification Number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided “incident to” the services of a physicians or non-physician practitioners (NPP), in which case it is required. CR4014 updates instructions in CR3648 (related to claims for services “incident to” a physician’s/NPP’s service) by acknowledging that:

- The “incident to” service can be identified only on prepay or post-pay review;
- Manual review of all therapy claims is not required; and
- Incident to policies have not changed and still apply to therapy services.

CR4014 also clarifies selected business requirements in CR3648 to indicate that some contractor actions:

- Will occur on prepay or post-pay review;

For example, compare the following:

Business Rule (BR) 3648.8 – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals;

with

BR 4014.8 – On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for **physical therapy and occupational** therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.

- Should not be applied to services “incident to.” (e.g., BR 3648.3 – Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or post-pay review).

CR3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed “incident to” a physician.

Therefore, when a therapy service is billed “incident to,” the following requirements remain in effect because they are required by “incident to” policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

Implementation

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

Additional Information

CR3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services) can be reviewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>

The MLN Matters article, MM3648 can be viewed on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf>

For complete details, please see the official instructions (CR4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR4014, the NCD, transmittal 55 is available at:

<http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf>

Transmittal 941 is the *Medicare Claims Processing Manual* update, which is available on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R941CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>



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

- Introduction to Medicare
- Modifiers
- Interpreting the Remittance Advice
- Understanding the '97 Evaluation & Management Guidelines

Continuing Education Units (CEUs) and Continuing Medical Education (CME) credit will not be issued for these courses any longer.

For more information visit your Medicare Carrier's website:

Arkansas	www.arkmedicare.com/provider/wbt
Louisiana	www.lamedicare.com/provider/wbt
Missouri	www.momedicare.com/provider/wbt
Oklahoma/New Mexico	www.oknmmedicare.com/provider/wbt
Rhode Island	www.rimedicare.com/provider/wbt



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:

Arkansas <i>www.arkmedicare.com</i>	Louisiana <i>www.lamedicare.com</i>	Missouri <i>www.momedicare.com</i>	Oklahoma/New Mexico <i>www.oknmmedicare.com</i>	Rhode Island <i>www.rimedicare.com</i>
Pinnacle Medicare Part B Attn: Provider Education Specialist P.O. Box 1418 Little Rock, AR 72203-1418	Pinnacle Medicare Services Attn: Provider Education Specialist P.O. Box 83760 Baton Rouge, LA 70884-3760	Pinnacle Medicare Services Attn: Provider Education Specialist P.O. Box 1418 Little Rock, AR 72203-1418	Pinnacle Medicare Services Attn: Provider Education Specialist P.O. Box 83760 Baton Rouge, LA 70884-3760	Pinnacle Medicare Services Attn: Provider Education Specialist P.O. Box 249 Providence, RI 02901

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.

Was our response clear and easy to understand? _____

Was our staff member friendly and helpful? (If not, what happened?) _____

General comments: _____

Interactive Voice Response Unit:

Do you use the IVR regularly? (If not, why not?) _____

Do you find the IVR to be an effective tool for you and your staff? (Why or why not?)

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.)

(continued on next page)



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.

Probe Review Results of Initial Hospital Care Evaluation and Management Codes 99221 - 99223 in Arkansas

Reference: AR – HDM 050106

A widespread pre-pay probe review was performed for initial hospital care evaluation and management (E/M) services in Arkansas, for CPT® codes 99221 - 99223. The following criteria were utilized:

- Provider Specialties: 08 (Family Practice)
- Place of Service: 21 (Inpatient Hospital)
- Dates of Services: November 21, 2004 through November 8, 2005
- Procedure Codes:
 - Ø **CPT 99221** – Initial Hospital Care, per day, for the evaluation and management of a patient, which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Usually the problem(s) requiring admission are of low severity.
 - Ø **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.
 - Ø **CPT 99223** – 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 high complexity. Usually the problem(s) requiring admission are of high severity.

Current Procedural Terminology © 2004 American Medical Association. All Rights Reserved.

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. Insufficient documentation accounted for 29.4% of the errors.
- The specialties and codes selected for interventions were identified using national data. Distribution analysis was performed in each state to determine which specialties and codes exceeded the nation in allowed services per 1000 beneficiaries. The specialties and codes identified as outliers were analyzed further using Carrier data to determine if the problem was widespread or provider specific.
- In Arkansas, Specialty 08 was identified in Carrier data as the greatest outlier in distribution analysis. Specialty 08 exceeded the national average by 1.8 times in allowed services per 1000 beneficiaries for CPT 99223 and by 2.3 times in allowed services per 1000 beneficiaries for CPT 99222.
- Widespread prepay probes will be performed in all states to evaluate the provider community for billing practices for initial hospital services, to establish a baseline error rate, and to ensure that providers are knowledgeable of coverage, coding, and billing requirements in FY 2006.
- The overall goals are to establish and lower the claims payment error rate and to ensure appropriate utilization and documentation of these services by providers.

Probe Results for CPT 99221 - 99223:

A total of 103 claims, 103 services, for CPT codes 99221 - 99223, were randomly selected for prepay review. Of the 103 services reviewed:

- 30 were supported as billed.
- 73 were denied for the following reasons:
 - Ø 21 services were down-coded to a lesser evaluation and management service. Documentation received did not support the code billed and was reduced to the highest, most appropriate CPT code supported.
 - Ø 26 services were denied as no response to the request for additional documentation.



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.

- Ø 24 services were denied as insufficient documentation was received.
- Ø 1 service was denied as not medically necessary. There was no clear reason for the admission to the hospital. The history and physical exam were not included with documentation submitted.
- Ø 1 service was denied as it was not provided. According to documentation received, the patient was not admitted by the billing physician.

Issues Identified from Probe:

- Services were down-coded for the following reasons:
 - Ø Documentation samples did not meet the level of decision making needed to justify the medical necessity for this level of service.
 - Ø Insufficient past, family, social, medical history documented to meet the criteria for the code billed.
 - Ø Several documentation samples failed to include the review of systems.
 - Ø Documentation failed to meet key components for any level of initial care service.
 - Ø Documentation samples did not contain a history or physical exam for the date of service billed.
- The provider did not send in documentation in response to Medical Review's Additional Documentation Request (ADR).
- Twenty-four services were denied for insufficient documentation.
 - Ø Provider may have sent in documentation, but not for the date requested.
 - Ø The ADR was returned without documentation.
 - Ø Documentation was not signed by the billing provider.
- Some of the documentation was poorly legible, making the review limited.

Recommendations for Providers:

- Review the 1995 and 1997 Evaluation and Management Guidelines, which may be found at www.cms.hhs.gov/MedlearnProducts/20_DocGuide.asp#TopOfPage
- Send documentation for future requests within the 30 day time-frame.
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.
- Ensure that documentation is legible. This 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.
- Ensure that documentation is clearly identified, supports the medical necessity for the service billed, is submitted for the dates of service requested, and is signed by the provider.
- It is important to bill the appropriate procedure code for the actual service provided.
- 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. While the title is "Subsequent Hospital Care," the guidelines in the article apply to all E/M codes.
- Please review the *Medicare Claims Processing Manual*, Chapter 12, section 30.6.1, 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."

References:

- 1995 and 1997 Documentation Guidelines for Evaluation and Management Services
- *Current Procedural Terminology*, CPT 2005, Professional Edition © 2004 American Medical Association. All Rights Reserved.
- *Medicare Providers' News*, May 2004, "Coding of Subsequent Hospital Care"
- *Medicare Claims Processing Manual*, Chapter 12, section 30.6.1
CPT® is a trademark of the American Medical Association.



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.

Denial Management Workshops

Reference: LA – MRD 051806

We encourage all Providers to attend one of our half-day Denial Management workshops designed specifically for Medicare providers and their billing staff. The purpose of this workshop is to provide educational information regarding how to address Medicare denials. The primary discussion will relate to the top denial reasons and will include recommendations about how to address these denials as well as how to prevent them in the future.

WHO SHOULD ATTEND? We encourage all Medicare providers, practice/office managers, compliance officers and billing personnel to attend.

This workshop is absolutely FREE for all participants. Seating will be limited therefore pre-registration is required. Pre-registration can be completed online at <http://www.lamedicare.com/provider/Events/default.aspx>. If access to the internet is not available, registration will be accepted via U.S. Mail. Please mail registration to:

**Pinnacle Business Solutions
P.O. Box 83760
Baton Rouge, LA 70884**

or

FAX to (225) 231-2276

Cost	Date	City, State	Time	Location/Attendance Limit	Workshop #
FREE	June 20, 2006	Bossier City, LA	8:30 a.m. – 12:00 p.m.	Willis Knighton Bossier Health Center Conference Room 2400 Hospital Drive Bossier City, LA 71111	LDM01
FREE	June 22, 2006	Baton Rouge, LA	8:30 a.m. – 12:00 p.m.	Pinnacle Business Solutions Conference Room 7159 Florida Blvd. Baton Rouge, LA 70806	LDM02
FREE	June 23, 2006	Baton Rouge, LA	8:30 a.m. – 12:00 p.m.	Pinnacle Business Solutions Conference Room 7159 Florida Blvd. Baton Rouge, LA 70806	LDM03



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.

Probe Review Results of CPT 71010, Chest X-ray, Louisiana

Reference: AR - HDM 051006

A widespread pre-pay probe review was performed on utilization of chest x-ray services in Louisiana. The following criteria were utilized:

- Provider Specialty: 30 (Diagnostic Radiology) and 63 (Independently-billing portable x-ray supplier)
- Procedure Codes:
 - Ø CPT® 71010: *Radiologic examination, chest; single view, frontal*
 - Ø 26 modifier: Professional Component;
Current Procedural Terminology © 2004 American Medical Association. All Rights Reserved.
- Dates of Services: December 5, 2005 through January 24, 2006

Rationale for Review:

- Chest x-ray (CXR) was originally identified as a focus area in the FY 2005 strategy. This probe was a six month follow up to evaluate the effectiveness of an educational article published in the *Medicare Providers' News* after a widespread probe was completed in all states in 2005.
- Although chest x-ray services accounted for <1% of the total CERT errors for the Arkansas Medicare Coverage Area for the time period October 2003 through March 2004, excluding non-responders; insufficient documentation accounted for 100% of the errors.
- The overall goals are to establish and lower the claims payment error rate and to ensure appropriate utilization and documentation of these services by providers.
- Carrier data shows a 5% increase in allowed services for procedure code 71010 and a 7% increase in allowed services for procedure code 71020 when comparing January through June 2004 with January through June 2005.

Results of the FY 2005 widespread probe:

A total of 108 services, for procedure codes 71010 and 71020 (*Radiologic examination, chest; two views, frontal and lateral* Current Procedural Terminology © 2003 American Medical Association. All Rights Reserved) were randomly selected for prepay review. Of the 108 services billed:

- Seventy-five (75) were supported as billed
- Thirty-three (33) were denied for the following reasons:
 - Ø Eight (8) services were denied due to lack of medical necessity.
 - Ø Seven (7) services were denied as insufficient documentation was received (no progress notes submitted).
 - Ø Eighteen (18) services were denied due to no response to the Additional Documentation Requests (ADR)

Review of the seven claims denied for lack of medical necessity revealed the following:

- Ø Diagnoses submitted on the claims were not verified in the medical records.
- Ø No signs or symptoms of disease or injury were documented, supporting the need for a chest x-ray.
- Ø Handwriting was illegible.
- Ø Chest x-rays were performed for pre-operative screening.

Results of the FY 2006 widespread probe:

A total of 109 services, for procedure code 71010 were randomly selected for prepay review. Of these 109 services billed:

- Forty-seven (47) were supported as billed.
- Sixty-two (62) were denied for the following reasons:
 - Ø Fifty (50) services were denied due to lack of response to Additional Documentation Requests (ADR) within the 30 day time frame.



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.

- Ø Seven (7) services were denied because the requested information was not received. Denials resulted if providers submitted incomplete or illegible documentation.
- Ø Four (4) services were denied because documentation did not establish medical necessity.
- Ø One (1) service was denied as the service was not provided.

Issues Identified from Probe:

- No response to the Additional Documentation Request (ADR):
 - 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 or failure to send in the appropriate documentation which was requested, will result in denial of your claims.
- The provider sent in some documentation, but it was incomplete (i.e., missing the test result) or illegible.
- The four (4) services denied as not medically necessary had no documentation of signs, symptoms, illness, or injury to support the service. This procedure is not payable based on a diagnosis code only. The reason for the test, along with the results, should be clearly documented.
- One service was denied as it was not provided. Documentation submitted for review did not include an order for a chest x-ray or a test result. There was no indication that a chest x-ray had been performed by the billing provider.

Recommendations for Providers:

- Review the Local Coverage Determination (LCD), AC-01-005, entitled *Chest X-ray*, for documentation requirements.
- In the future, please make sure all documentation is legible, for the dates of service requested, and submitted within the thirty day time frame for medical review.
- When billing for the technical component only, the TC modifier must be attached and the medical record must include the same documentation as the total component, except for the results of the test. This may include such things as physician's orders, patient's signs and symptoms, or some discussion explaining the rationale for the chest x-ray.
- When billing for the professional component only (interpretation), the -26 modifier must be attached and medical records must have the following documentation: chest x-ray interpretation, including the medical necessity for the test.
- Additional guidelines in regard to billing for chest x-rays include:
 - Ø Medicare provides coverage for chest x-rays that are medically necessary based on signs, symptoms, illnesses, injuries, or diseases. The presence of an acceptable ICD-9 code does not in itself support medical necessity.
 - Ø Specific symptoms or findings, such as cough, hemoptysis, dyspnea, recent conversion of a tuberculosis (TB) skin test from negative to positive, or fever of undetermined origin, constitute medical necessity for performing chest x-rays.
 - Ø Medical conditions with manifestations involving chest structures, such as metastatic carcinoma or congestive heart failure, are indications for performing chest x-rays.
 - Ø Chest x-rays are also covered when performed to follow up an invasive procedure, such as thoracentesis, or central venous line placement.
 - Ø Pre-operative chest x-rays are covered if the patient is scheduled for major surgery and has risk factors which make the x-rays medically necessary. The risk factors must be clearly stated in the patient's medical record and documented on the claim in the form of a medically necessary ICD-9-CM code. A pre-operative evaluation for screening purposes is not covered.
- When chest x-rays are done for pre-operative screening purposes only, a Notice of Exclusion from Medicare Benefits (NEMB) form should be obtained prior to performing the service and the GY modifier should be attached to the CPT code.



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References:

- *CPT 2005 Current Procedural Terminology* © 2004 American Medical Association. All Rights Reserved.
 - *CPT 2006 Current Procedural Terminology* © 2005 American Medical Association. All Rights Reserved.
 - Local Coverage Determination, AC-01-005, *Chest X-ray*, available at www.lamedicare.com/provider/medpolb
 - Comprehensive Error Rate Testing (CERT) information, <http://www.lamedicare.com/provider/cert/cert.asp> or <http://www.cms.hhs.gov/cert>
- CPT® is a trademark of the American Medical Association.



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.

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.

Denial Management Workshops - Oklahoma

Reference: LA – DBC 051706

We encourage all Providers to attend one of our half-day Denial Management workshops designed specifically for Medicare providers and their billing staff. The purpose of this workshop is to provide educational information regarding how to address Medicare denials. The primary discussion will relate to the top denial reasons and will include recommendations about how to address these denials as well as how to prevent them in the future.

WHO SHOULD ATTEND? We encourage all Medicare providers, practice/office managers, compliance officers and billing personnel to attend.

This workshop is absolutely FREE for all participants. Seating will be limited therefore pre-registration is required. Pre-registration can be completed online at <http://www.oknmmedicare.com/provider/Events/default.asp>. If access to the internet is not available, registration will be accepted via U.S. Mail or fax to (225) 231-2276.

Cost	Date	City, State	Time	Location/Attendance Limit	Workshop #
FREE	June 27, 2006	Tulsa, OK	8:30 a.m. – 12:00 p.m.	Tulsa Technology Center Riverside Campus Alliance and Conference Center 801 East 91 st Street	ODM01
FREE	June 28, 2006	Norman, OK	8:30 a.m. – 12:00 p.m.	Norman Regional Hospital Auditorium 901 North Porter	ODM02

Denial Management Workshops – New Mexico

Reference: LA – DBC 051706

We encourage all Providers to attend one of our half-day Denial Management workshops designed specifically for Medicare providers and their billing staff. The purpose of this workshop is to provide educational information regarding how to address Medicare denials. The primary discussion will relate to the top denial reasons and will include recommendations about how to address these denials as well as how to prevent them in the future.

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Cost	Date	City, State	Time	Location/Attendance Limit	Workshop #
FREE	June 13, 2006	Albuquerque, NM	8:30 a.m. – 12:00 p.m.	Lovelace Sandia Hospital Education Building – Auditorium 5400 Gibson Blvd. SE	NDM01
FREE	June 22, 2006	Las Cruces, NM	8:30 a.m. – 12:00 p.m.	Hilton Las Cruces Guadalupe Room 705 South Telshor Blvd. Las Cruces, NM 88011	NDM02



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.

PBSI Announces Closure of Providence Office

Reference: AR – TAM 041706

Pinnacle Business Solutions, Inc. (PBSI), a wholly-owned subsidiary of Arkansas Blue Cross and Blue Shield (ABCBS) will close its Providence, Rhode Island Medicare office effective June 30, 2006. PBSI will maintain a local presence in Rhode Island with the retention of its Warwick office to serve Rhode Island healthcare providers (Provider Audit & Reimbursement along with Professional Services staff).

PBSI is the Medicare contractor for both the Part A and Part B programs in Arkansas and Rhode Island; and is the Medicare Part B carrier for the states of Louisiana, Oklahoma, New Mexico, and eastern Missouri. PBSI will consolidate its Rhode Island work to its other PBSI Medicare locations as a part of an overall consolidation and restructuring currently underway for all Medicare functions. The consolidation of this work into other PBSI operational sites will result in savings and efficiencies in the operation of the Medicare Program. Rhode Island beneficiaries and providers will continue to receive uninterrupted service from experienced staff in PBSI's other offices.

Professional Services personnel will be available to assist with problems and meet your Medicare educational needs. We are committed to continuing our good working relationship with the Rhode Island providers and consider local provider education a priority.

Watch the "pop-up" box for changes as we move forward with the consolidation of operations. Any changes to P.O. Boxes, phone numbers, or procedures will be communicated in advance of the changes.

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
- Louisiana (866) 567-8419 www.lamedicare.com
- Missouri..... (866) 736-0799 www.momedicare.com
- Oklahoma (866) 280-6520 www.oknmmedicare.com
- New Mexico..... (866) 280-6520 www.oknmmedicare.com
- Rhode Island..... (866) 801-5304 www.rimedicare.com

Medicare Provider News is published monthly by Pinnacle Medicare Services. It provides billing and coverage information to providers in the six states. Pinnacle Business Solutions, Inc. serves whose patients are covered under Medicare Part B.

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.

Editor: Scott Thier, Coordinator
Medicare Communications

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This bulletin should be shared with all health care practitioners and managerial members of the physician/supplier staff. *Medicare Providers’ News* is available at no cost from your state’s website listed on the back cover of this newsletter.

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