# Pinnacle Medicare Providers' News

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

## What's In This Issue?

Alert....5
Arkansas....52
Clinical Laboratory....7
Coding & Coverage....8
Competitive Acquisition Program (CAP)....17
Comprehensive Error Rate Testing (CERT)....21
Drug Administration....22
Electronic Data Interchange (EDI)....24
General....25
Louisiana....53
Missouri....54
Medicare Physician Fee Schedule....35
Medicare Secondary Payer (MSP)....37
Medicare Summary Notice (MSN)....39
National Provider Identifier (NPI)....40
Oklahoma/New Mexico....55
PET Scans....42
Provider Identification Number (PIN)....45
Rhode Island....56

## Table of Contents

2006 MPFSDB, July Update ..... 35
Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment ..... 12
Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment; Manualization ..... 14
Competitive Acquisition Program (CAP) – Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Instructions for Claims Received from RRBB ..... 17
Competitive Acquisition Program (CAP) for Part B Drug and Biologicals Beneficiary Fact Sheet ..... 19
Competitive Acquisition Program (CAP) Physician Election Period Extension ..... 20
Correct Coding Initiative Edits Quarterly Update, Version 12.2, Effective July 1, 2006 ..... 16
Drug Administration Coding and Payment Policy – Update to Claims Processing Manual ..... 22
E&M Services Provided During Global Period of Surgery ..... 8
Electrical Stimulation – Manual or Unattended ..... 25
EMC Edits Effective July 3, 2006 ..... 24
Emergency Department E&M Services ..... 26
Go Electronic – Save Administrative Dollars Today ..... 5
Have a Question? ..... 49
Laboratory National Coverage Determination (NCD) Edit Software for July 2006 ..... 7
Laboratory Services, Requirements for Referring Providers ..... 28
Locum Tenens/Reciprocal Billing Arrangements and Use of Q5 and Q6 Modifiers ..... 31
MedGuide Order Form ..... 3
Medicare Identification Numbers ..... 45
Medicare Secondary Notice (MSN) Printing Cycle, Quarterly ..... 39
Medicare Secondary Payer (MSP) Balancing Edits ..... 37
Medicare Secondary Payer (MSP) Questionnaire Modifications ..... 38
Multiple Endoscopies Billing Clarification ..... 30
National Provider Identifier (NPI) Numbers Received in EDI Transactions, via Direct Data Entry Screens, or Paper Claim Forms ..... 40
Pancreas Transplants Alone ..... 10
Paper Distribution of Medicare Providers' Newsletter ..... 4
PET Scans in CMS-Approved Clinical Trials and Coverage with Evidence Development ..... 42
Physician Self-Dialysis Training Services ..... 9
Prosthetic Implants or Implantable Durable Medical Equipment that is Surgically Inserted at an Ambulatory Surgical Center ..... 11
Reminder to Enumerate; Countdown has Begun ..... 41
Seminar Registration ..... 48
Web-Based Training ..... 47
Your Feedback is Greatly Appreciated! ..... 50

***Arkansas (52)***
Audit Guidelines for CPT codes 11040-11043 ..... 52

***Louisiana (53)***
Audit Guidelines for CPT codes 11040-11043 ..... 53

***Missouri (54)***
Audit Guidelines for CPT codes 11040-11043 ..... 54

***Oklahoma/New Mexico (55)***
Audit Guidelines for CPT codes 11040-11043 ..... 55

***Rhode Island (56-57)***
Audit Guidelines for CPT codes 11040-11043 ..... 57
PBSI Announces Closure of Providence Office ..... 56

## Pinnacle Medicare Services offers an electronic manual (MedGuide) that contains important information to help you submit Part B claims correctly.

**The MedGuide manual, available on CD-Rom and the Internet contains:**

- All Pinnacle Medicare Services policies
- Coverage guidelines by specialty (i.e., ambulance, chiropractors, pathology, ophthalmology, psychiatry, etc.)
- Billing instructions
- Information about becoming a Medicare provider

The MedGuide manual includes general information about billing Medicare Part B as well as state specific policies and specific information for billing the Medicare Part B carrier in your state. The price for MedGuide is:

- $100.00 for the CD-ROM (single user)
- Free on the Internet (on your state's website)

The fee for the CD-ROM version includes updates three times a year for the calendar year in which MedGuide was purchased. In February of each subsequent year, we will issue an invoice for renewal of your MedGuide update subscription.

To obtain your copy of MedGuide, please complete the information below and **return this form with a check for the appropriate amount**. Make checks payable to 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**

## Paper Distribution of Medicare Providers' Newsletter

Providers with the inability to receive electronic bulletins who wish to continue receiving paper bulletins may do so for an annual fee of $100.00 per bulletin type. Utilize the form below to submit your request. Please be sure to include the reason you have chosen to receive paper rather than utilizing the web site.

Please join our list-serve to receive notification of updated information. You may sign up for the list-serve by accessing your state's web site at the following address:

| | |
|---|---|
| **Arkansas** | www.arkmedicare.com |
| **Louisiana** | www.lamedicare.com |
| **Missouri** | www.momedicare.com |
| **New Mexico** | www.oknmmedicare.com |
| **Oklahoma** | www.oknmmedicare.com |
| **Rhode Island** | www.rimedicare.com |

You can eliminate wasted time searching our web site for updates or seminar information. By joining our mailing list(s), you will get information very timely. You can be up-to-date on the latest Medicare changes before they are printed in the *Medicare Provider News* bulletins by subscribing to our web site mailing list. Once you subscribe, we will be able to contact you via e-mail whenever our website is updated and of changes in the Medicare Program. Subscribing to our website mailing list is as easy as 1 – 2 – 3! Just go to your state's website and click on the word *Subscribe* located on top of every page. Complete the registration form and select the mailing list(s) you wish to be added to. After completing the form click on the Submit button. You should receive 2 confirmation messages. The first message will help us verify that we can contact you via email, and that no one is using you email address anonymously. You will be required to confirm that you received this message by responding back to it. Once your confirmation is received you will be added to the requested mailing list(s). You will receive a second email stating that you have been successfully subscribed to the request mailing list. You will now be contacted via the submitted email address whenever our web site is updated. You will receive an e-mail that includes a brief description of the update and a link to the complete publication.

Name:______________________________________________

Attn:________________________________ Telephone: ____________

Provider Number (if applicable):______________ E-Mail Address: ______________

Street Address (include zip):________________________________

______________________________________________

Reason: ______________________________________________

______________________________________________

Indicate bulletin preference(s):

___ Part B Newsletters & Policy Notices

___ Part A Newsletters & Policy Notices

**Please return this form and payment (checks payable to Pinnacle Medicare Services) to:**

**Pinnacle Medicare Services - Communications**
**Attn: Scott Thier**
**12755 Olive Blvd.; Ste. 105**
**Creve Coeur, MO 63141**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

## *Alert*

# GO ELECTRONIC $$$

## Save Administrative Dollars Today!

## Pinnacle Medicare Services Electronic Data Interchange

## Contact our EDI Team at:

## 1-866-582-3247

There is a way to maximize your staff's time and increase efficiency in your work place. Process all of your Medicare transactions electronically today:

- Electronic Claims Filing
- Electronic Remittance Advice
- Medicare Remit Easy Print
- HIPAA Compliant Transactions
- Electronic Funds Transfer

**Electronic Claims Filing**

Filing Claims Electronically is easy with Medicare's FREE software. Filing claims in an electronic HIPAA compliant format allows quicker processing compared to paper claims.

**Medicare Claims Express (MCE)**

MCE is a submission software package that provides you with the capability to transmit Medicare Part B claims electronically in the American National Standard Institute (ANSI) X12 format. MCE is designed for use on a stand-alone personal computer and is not recommended for network use.

**Electronic Remittance Advice (ERA)**

Beginning June 1, 2006, Carriers and DMERCs will stop sending standard paper remittance advices if you have been receiving 835s or Electronic Remittance Advice (ERA) transactions.

**Medicare Remit Easy Print (MREP)**

Medicare Remit Easy Print software allows Medicare Part B providers to print the Electronic Remittance Advice in a readable format. The software is free and available for download on Pinnacle Medicare Service's web site.

**Health Care Eligibility Benefit Inquiry & Response Transaction (270/271 Transaction Code Set)**

This service provides real-time beneficiary eligibility information. To obtain access you will need to 1) Complete the EDI 270 Enrollment Packet; and 2) Obtain the necessary telecommunication software from the AT&T reseller. The current AT&T resellers are:

- IVANS: www.ivans.com
  1-800-548-2675
- McKesson: www.mckesson.com
  1-800-782-7426, option 5, then key option 8

**Health Care Claim Status Request and Response (276/277 Transaction Code Set)**

This service conveys claims status information on claims received by Medicare. This transaction will help answer questions such as:

- *Did you receive my claims?*
- *Where are my claims in your system?*
- *What is the status of my claims (Paid, rejected, in-process, etc.)?*

To take advantage of the 276/277 Health Care Claim Status Request and Response, providers must complete both a:

1. ANSI 4010A1  276/277 Claims Status Inquiry Enrollee Information Form, and
2. Trading Partner Agreement

**Electronic Funds Transfer (EFT)**

Electronic Funds Transfer (EFT) allows Medicare to make payments directly into your banking account, so there is no more waiting for checks in the mail.

**Need More Information?**

- Ø Filing Claims Electronically
- Ø Medicare Remit Easy Print
- Ø Health Care Eligibility Benefit Inquiry and Response Transaction
- Ø Health Care Claim Status Request and Response Transaction

Visit your state's Medicare web site or contact: Electronic Data Interchange (EDI) Services at 1-866-582-3247.

Medicare web site:

| | |
|---|---|
| **Arkansas:** | www.arkmedicare.com |
| **Louisiana:** | www.lamedicare.com |
| **Missouri:** | www.momedicare.com |
| **Oklahoma/New Mexico:** | www.oknmmedicare.com |
| **Rhode Island:** | www.rimedicare.com |

For more information regarding: Electronic Funds Transfer (EFT), visit your state's Medicare web site or contact the Provider Enrollment Department:

| | |
|---|---|
| **Arkansas/Rhode Island:** | 1-866-582-3251 |
| **Louisiana:** | 1-866-794-0466 |
| **Missouri:** | 1-866-419-9460 |
| **Oklahoma/New Mexico:** | 1-866-582-3251 |

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

*Reference: Trans. 959, CR #5108, Pub. 100-04, Medlearn Matters Number: MM5108*

***Provider Types Affected***

Physicians, providers, and suppliers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for clinical diagnostic laboratory services provided for Medicare beneficiaries

***Impact on Providers***

This article is based on Change Request (CR) 5108, which communicates requirements to Medicare contractors (carriers and FIs) notifying them of changes to the laboratory edit module and to update the laboratory edit module for changes in laboratory NCD code lists for July 2006.

***Background***

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

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub.100-4), Chapter 16, §120.2; http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf). These changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and several of the listed changes correct Current Procedural Terminology (CPT) codes to reflect the current CPT update.

CR5108 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for July 2006 that require updating of the laboratory edit module. The key change being made to the NCD code lists for July 2006 is that CPT code 83704 (Quantitation of lipoprotein particle numbers and lipoprotein particles subclasses) is being added to the list of HCPCS/CPT codes covered by Medicare for the Lipids Testing NCD.

***Implementation***

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

***Additional Information***

For complete details, please see the official instruction (CR5108) 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/R959CP.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 Evaluation and Management Services Provided During Global Period of Surgery

*Reference: Trans. 954, CR #5025, Pub. 100-04, Medlearn Matters Number: MM5025*

***Provider Types Affected***

Physicians and qualified non-physician practitioners (NPP) who bill Medicare carriers for their services

***Key Points***

- The Centers for Medicare & Medicaid Services (CMS) has clarified the documentation requirements and policy requirements for the use of CPT modifier -25 used with E/M services. Please refer to the manual attachment to CR5025, *The Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.6, for revisions regarding the use of CPT modifier -25.
- Physicians and qualified non-physician practitioners (NPP) should use CPT modifier -25 to designate a significant, separately identifiable E/M service provided by the same physician/qualified NPP to the same patient on the same day as another procedure or other service with a global fee period.
- Common Procedural Terminology (CPT) modifier -25 identifies a significant, separately identifiable evaluation and management (E/M) service. It should be used when the E/M service is above and beyond the usual pre- and postoperative work of a procedure with a global fee period performed on the same day as the E/M service.
- Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service with a global fee period. Modifier -25 is added to the E/M code on the claim.
- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified NPP in the patient's medical record to support the need for Modifier -25 on the claim for these services, even though the documentation is not required to be submitted with the claim.
- Your carrier will not retract payment for claims already paid or retroactively pay claims processed prior to the implementation of CR5025. But, they will adjust claims brought to their attention.
- Carriers will not pay for an E/M service reported with a procedure having a global fee period unless CPT modifier -25 is appended to the E/M service to designate it as a significant and separately identifiable E/M service from the procedure. Such payment will be denied with the following messages:

**Claim Adjustment Reason Code**

- **97** - Payment is included in the allowance for another service/procedure.

**Remittance Advice Remark Code**

- **M144** - Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

***Additional Information***

CR1250, Transmittal A-00-40, July 20, 2000, *Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services*, can be found on the CMS web site at:

http://new.cms.hhs.gov/transmittals/downloads/A0040.PDF

This article provides information that is especially helpful for emergency department use of modifier -25.

CR1725, Transmittal A-01-80, June 29, 2001, *Use of Modifier -25 and Modifier -27 in the Hospital Outpatient Prospective Payment System (OPPS)*, can be found on the CMS web site at:

http://new.cms.hhs.gov/Transmittals/Downloads/A0180.pdf

CR5025 is the official instruction issued to your carrier regarding changes mentioned in this article, MM5025. CR 5025 may be found by going on the CMS web site to:

http://www.cms.hhs.gov/Transmittals/downloads/R954CP.pdf

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

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

---

## Physician Self-Dialysis Training Services

*Reference: AR – TAM 060106; MCM Pub. 100-04, Section 150*

***Note: This article is a correction to the article published on page 29 of the April 2006 Medicare Provider Newsletter.***

Medicare Services will pay physicians for physician training services furnished to dialysis patients undergoing training associated with procedure code 90989 (Dialysis training, patient, including helper where applicable, any mode, completed course). This course of therapy will be reimbursed at a flat fee of $500, which is subject to the deductible and coinsurance.

If the training period is not completed, such as in instances where the patient can no longer be trained, we will prorate the training rate in proportion to the number of training treatments completed, but not to exceed $500. For purposes of this pro-ration, we consider 25 training treatments as a complete course of training. Therefore, for an incomplete training course, PBSI will pay the physician for the training services based on an amount of $20 per treatment times the number of treatments completed. This rule applies to all modes of treatment, including CAPD. The HCPCS code to be used is 90993 (Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session).

Occasionally, it is necessary to furnish additional training to an ESRD self-dialysis beneficiary after the initial training course is completed; e.g., because of a change from hemodialysis to peritoneal dialysis, a change in equipment. The amount of additional training required depends upon the transferability of the skills the patient has already learned; subsequent training would normally be very limited. Physicians' training services furnished during subsequent training of an ESRD beneficiary are covered and reimbursed in addition to the initial training fee.

Subsequent training sessions that are reimbursable under this rule must be distinguished from the ongoing services for which the original training fee is considered payment in full; e.g., answering the patient's questions arising after home dialysis has begun about the machine the patient has already been trained to use. No additional payment is made after the initial training course unless the subsequent training is required because of a change from the patient's treatment machine to a machine that he had not been trained to use in the initial training course, a change in the type of dialysis, or a change in setting or dialysis partner would be warranted. The same guidance as above applies in this case. The individual sessions would be billed using code 90993 with an allowance of $20 per session (subject to deductible and coinsurance).

In all situations where subsequent training sessions are provided, you must submit documentation as to the basis for the subsequent sessions when requested. This documentation will be reviewed to determine if the subsequent session can be allowed.

## Pancreas Transplants Alone (PA)

*Reference: Trans. 957 and 56, CR #5093, Pub. 100-04 and 100-03, Medlearn Matters Number: MM5093*

***Provider Types Affected***

Physicians and providers billing Medicare fiscal intermediaries (FIs) and carriers for PA

***Background***

Medicare covers whole organ pancreas transplantation when it is performed in conjunction with or after kidney transplantation (*National Coverage Determination (NCD) Manual*, Section 260.3). However, Medicare does not cover PA in diabetes patients without end-stage renal failure because of a lack of sufficient evidence, based in large part on a 1994 Office of Health Technology Assessment report.

***Key Points***

This article is based on information contained in Change Request (CR) 5093, which informs physicians and providers that, effective for services performed on or after April 26, 2006, Medicare will cover PA for beneficiaries in the following limited circumstances:

- Facilities must be Medicare-approved for kidney transplantation (Approved centers are found on the CMS web site at:

  http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage
- Patients must have a diagnosis of Type I diabetes:
  - Ø The patient with diabetes must be beta cell autoantibody positive; or
  - Ø The patient must demonstrate insulinopenia, defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will be considered valid only with a concurrently obtained fasting glucose <225 mg/dL.
- Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization.
- These complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks.
- Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems.
- Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immuno-suppression.
- Patients must otherwise be suitable candidates for transplantation.

**Billing and Claims Processing**

- The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with **HCPCS 48554**:

  25001, 25003, 25011, 25013, 25021, 25023, 25031, 25033, 25041, 25043, 25051, 25053, 25061, 25063, 25071, 25073, 25081, 25083, 25091, and 25093
- Carriers and FIs who receive claims for PA services that were performed in an **unapproved facility** should use the following messages upon the reject or denial:
  - Ø **Medicare Summary Notice MSN Message** - MSN code 16.2 *(This service cannot be paid when provided in this location/facility)*
  - Ø **Remittance Advice Message** - Claim 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 and FIs who receive claims for PA services that are **not billed using the covered diagnosis/procedure codes listed** above should use the following messages upon the reject or denial:
  - Ø **Medicare Summary Notice MSN Message** - MSN code 15.4 *(The information provided does not support the need for this service or item)*

- Ø **Remittance Advice Message** - Claim Adjustment Reason Code 11 *(The diagnosis is inconsistent with the procedure)*

- Modification of the current coverage policy on pancreas transplants can be found in Publication 100-02, Section 260.3 and claims processing information is located in Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the *Additional Information* section of this article.

**Note:** Carriers and FIs will hold any PA claims with dates of service on or after April 26, 2006, until the claims can be processed in their systems. For FIs this date is October 2, 2006, and for carriers the date is July 3, 2006.

***Implementation***

The implementation date for this instruction is no later than:

- July 3, 2006, for carriers; and
- October 2, 2006, for FIs.

***Additional Information***

The official instructions issued to your Medicare FI or carrier regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R56NCD.pdf for the NCD manual revision and http://www.cms.hhs.gov/Transmittals/downloads/R957CP.pdf for changes to the *Medicare Claims Processing Manual*.

If you have questions, please contact your Medicare FI 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

---

# Enrollment of Manufacturers of Replacement Parts and Supplies for Prosthetic Implants or Implantable Durable Medical Equipment that is Surgically Inserted at an Ambulatory Surgical Center

*Reference: JSM CI 3972-06465, 05-30-06*

Effective June 5, 2006, carriers shall not enroll manufacturers of implantable or non-implantable prosthetics durable medical equipment (DME) and replacement parts and supplies for prosthetic implants and surgically implantable DME into the Medicare program. Manufacturers of such items who wish to bill Medicare and receive payment must enroll in the Medicare program as a supplier with the National Supplier Clearinghouse (NSC). Any application currently in process with a Medicare carrier (not the NSC) will be denied for the reason that "the applicant does not qualify as a provider of services or supplier of medical and health services." Carriers make payments for implantable prosthetics and DME only to hospitals, physicians of Ambulatory Surgical Centers, and are thus precluded from enrolling manufacturers.

Any manufacturer or similar organization/entity that is currently enrolled in the Medicare program and billing a carrier for orthotic, prosthetics and/or miscellaneous DME will be notified by the carrier that their enrollment will be terminated 120 days after the notification. The notification will include the option for these entities to enroll as a DMEPOS supplier of non-implantable DMEPOS through the NSC within the 120 day timeframe, and a prohibition against billing Medicare for any implantable prosthetic or DME. The notification will give contact information for the NSC.

All DMEPOS suppliers must comply with all standards outlined in 42 CFR 424.57, and may not bill Medicare for any item prior to the issuance of its DMEPOS Medicare supplier billing number. Retroactive billing is also not permitted by DMEPOS suppliers in accordance with 42 CFR 424.57(b)(2).

## Medicare Policy Regarding Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

*Reference: Medlearn Matters Number: SE0638*

***Provider Types Affected***

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations.

***Background***

Once a Center for Medicare & Medicaid Services (CMS) data system recognizes a beneficiary has enrolled in a MA Organization, the MA organization receives capitation payments for the beneficiary. In some cases, enrollments with retroactive dates are processed. The result is that Medicare may pay for the services rendered during a specific period twice; once for the specific service which was paid by the fee-for-service Medicare contractor and secondly by the MA Payment systems in the monthly capitation rate to the plan. Change Request 5105 and MLN Matters 5105 (see http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5105.pdf) describe how CMS ensures that any fee-for-service claims that are approved for payment erroneously are adjusted and overpayments recovered by Medicare carriers and/or FIs.

A variety of CMS systems issues over the past 18 months prompted CMS to recently synchronize Medicare Advantage enrollment and disenrollment information. As a result, providers may have claims that were affected by this synchronization in one of two ways, both of which are addressed below.

**Scenario 1. Claims Paid in Error**

About 386,000 claims for about 100,000 beneficiaries enrolled in MA organizations have been identified as having been paid on a fee-for-service basis by FIs or carriers during this time. FIs and carriers will, over the next 6 months, adjust these claims and seek overpayments.

Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate Reason Code 24 which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan". Upon receipt, providers are to contact the MA plan for payment.

***Providers who bill carriers:***

The carrier will alert you via letter or alternate method of the following:

- The beneficiary was in a MA plan on the date of service;
- You should bill the managed care plan;
- The plan identification number; and
- Where to find the plan name and address associated with the plan number on the CMS internet site.

***Providers who bill FIs:***

The adjustment will occur automatically, and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly. To associate plan identification numbers with the plan name, go to http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage on the CMS web site.

The number that will appear on the contractor notices will begin with 'H'. For the following 11 plans, the alpha prefix is actually an 'R'. A technical correction will be made in CMS systems in October 2006. Prior to October, when using the web page look up tool, make sure to replace the 'H' with an 'R'. The 11 plans are:

- R3175
- R5287
- R5342
- R5553
- R5566
- R5595
- R5674

- R5826
- R5863
- R5941
- R9943

***MA Plans have been notified:***

MA plans know that the resynchronization may result in an increase in payment requests from providers who had claims previously paid, but subsequently overturned by fee-for-service FIs and carriers. Whenever CMS reverses fee-for-service payments as a result of confirmed retro-active enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary. The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

**Scenario 2. Claims Denied in Error**

Because CMS has synchronized Medicare Advantage enrollment and disenrollment information, it is possible that fee-for-service claims were previously denied because the beneficiary was incorrectly identified as being a member of an MA plan. If a provider believes past claims have been denied in error due to problems in enrollment and disenrollment information, those claims can now be resubmitted. For any Part B services, the 10% reduction for timely filing will be waived.

***Additional Information***

For more information regarding the manualization of this policy, see the MLN Matters article on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5105.pdf

If you have questions regarding this issue, contact your carrier/FI at their toll-free number, which may be found on the CMS web site at:

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

## Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (Previously CR2801 Program Memorandum Transmittal AB-03-101) - Manualization

*Reference: Trans. 97, CR #5105, Pub. 100-06, Medlearn Matters Number: MM5105*

### *Provider Types Affected*

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations.

### *Impact on Providers*

This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a MA Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

### *Background*

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

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

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

**Overview of the MA plan Enrollment Process**

When an MA plan enrollment is processed retroactively:

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

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

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

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

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

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. To see details of the impact of this synchronization on providers, please see *MLN Matters* article, SE0638, which is available on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf

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

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

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

In summary, CMS issued CR5105 to:

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

***Implementation***

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

***Additional Information***

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

http://www.cms.hhs.gov/Transmittals/downloads/R97FM.pdf

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

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

## Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 12.2, Effective July 1, 2006

*Reference: Trans. 965, CR #5064, Pub. 100-04, Medlearn Matters Number: MM5064*

***Provider Types Affected***

Physicians billing Medicare carriers

***Provider Action Needed***

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on July 1, 2006. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at http://www.cms.hhs.gov/NationalCorrectCodInitEd/ on the Centers for Medicare & Medicaid (CMS) web site.

The web site will be updated with the Version 12.2 edits as soon as they are effective.

***Background***

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, Version 12.2, is effective on July 1, 2006. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables:

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

***Additional Information***

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found on the CMS web site at:

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

# Competitive Acquisition Program (CAP) - Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Additional Instructions for Claims Received from Railroad Retirement Board Beneficiaries

*Reference: Trans. 953, CR #5079, Pub. 100-04, Medlearn Matters Number: MM5079*

***Provider Types Affected***

Physicians submitting claims to carriers for services to Medicare beneficiaries under the CAP

***Impact on Providers***

This article is based on Change Request (CR) 5079, which provides additional information and instructions for the implementation of the CAP pertaining to CAP drug categories and fee schedule as outlined in CR4064 (Transmittal 777, dated December 9, 2006).

***Background***

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

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

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

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

CR4064 (Transmittal 777, dated December 9, 2006) described requirements for carriers to develop provider files that list physicians who have enrolled with an approved CAP vendor and the category (or categories) of drugs that the CAP vendor will furnish under the CAP.

CMS is issuing CR5079 to automate the process of updating the list of drugs paid under the CAP. CR5079 provides additional information and instructions for the implementation of the CAP pertaining to the CAP drug categories and fee schedule as outlined in:

- CR4064 (Transmittal 777, dated December 9, 2006 at http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf); MLN Article MM4064 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf; and
- CR4309 (Transmittal 866, dated February 6, 2006 (rescinded and replaced with transmittal 866 dated February 17, 2006 at http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf); MLN article MM4309 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf.

For the table defined in CR4064.1.1.2.1, when Medicare carriers receive election forms from providers, the carriers will indicate for each provider:

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

**CAP Drugs and Drug Categories**

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

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

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

**Changes to the Drug List**

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

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

**Payment Amount**

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

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

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

**Disaster Contingency**

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

**Claims for Railroad Retirement Board (RRB) Beneficiaries**

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

***Implementation***

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

***Additional Information***

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

http://www.cms.hhs.gov/Transmittals/downloads/R953CP.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

---

## Announcement of Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals Beneficiary Fact Sheet

*Reference: JSM CI 3986-06475, 06-07-06*

Visit http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage and scroll to the bottom of the page to download the Beneficiary Fact Sheet for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals. Physicians who elect to participate in the CAP are required to provide the CAP Beneficiary Fact Sheet to Medicare beneficiaries who are receiving certain Part B physician-administered drugs.

## Extension of the Competitive Acquisition Program (CAP) Physician Election Period

*Reference: Medlearn Matters Number: SE0639*

### *Provider Types Affected*

Physicians who wish to bill Medicare carriers for certain Part B drugs and biologicals under the Medicare CAP and have not yet elected to participate in the program.

### *Background*

The Centers for Medicare & Medicaid Services (CMS) has announced an extension of the election period for physician enrollment in the CAP for Part B Drugs and Biologicals. The initial physician election period from May 8 - June 2, 2006, was established on April 27, 2006.

**The physician election period has been extended until June 30, 2006.**

CMS is taking this action to provide physicians with a greater opportunity to evaluate the program and determine if the program is right for them. For the list of MLN articles that describe the CAP program in detail please see the *Additional Information* section of this article.

### *Key Points*

This Special Edition, SE0639, outlines the key implementation points as follows:

- CAP claims processing will start as planned on July 1, 2006, for physicians who submitted their forms by June 2, 2006.
- CMS is extending the election period until June 30, 2006. During this period all physicians, as defined by Change Request (CR) 4404, who have not already submitted election forms to their local carriers can elect to participate in CAP. (CR4404 can be found at http://www.cms.hhs.gov/Transmittals/downloads/R932CP.pdf on the CMS web site.)
- The effective date for elections postmarked by June 30 will be August 1, 2006. Completed election forms must be returned by mail to the physician's local carrier.
- By July 28, the approved CAP vendor, Bioscrip Inc., will contact any physicians who submit their election forms during this extended period, to let them know that they may begin ordering CAP drugs as of August 1, 2006.

### *Additional Information*

Further information regarding the CAP program is available on the CMS web site at:

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

Also, additional MLN Matters articles are available as follows:

- MLN Matters MM4064 provides a complete overview of the CAP and background material for SE0639. It can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf on the CMS web site.
- MLN Matters MM4309 builds on the business requirements outlined in MM4064, related to SE0639, and can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf on the CMS web site.
- MLN Matters MM4404, which relates to CR4044, can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf on the CMS web site.

If you have questions, please contact your Medicare 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

## *Comprehensive Error Rate Testing (CERT)*

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

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

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

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

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

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

## Drug Administration Coding and Payment Policy – Update to Publication 100-04 Medicare Claims Processing Manual

*Reference: Trans. 968, CR #5028, Pub. 100-04, Medlearn Matters Number: MM5028*

***Provider Types Affected***

Physicians and providers billing Medicare carriers for drug administration procedures

***Providers Action Needed***

This article and Change Request (CR) 5028 provide specific information regarding the interim G codes that were adopted in 2005 and operational until 2006 when the new Current Procedural Terminology (CPT) codes become operational. In **2006 CPT codes replace the interim G codes**. Beginning in 2006 physicians will follow CPT coding guidelines and select codes that best represent the underlying service. Implementation of these revised coding guidelines will help Medicare make prompt and correct payments for drug administration services.

Under the Medicare Modernization Act (MMA), drug administration codes included three categories of services for which there were no work relative value units as of October 1, 2003:

- Hydration
- Therapeutic, prophylactic, and diagnostic injections and infusions
- Chemotherapy administration

The MMA established work relative value units for these codes and provided transitional payment adjustments in 2004 and 2005. Carriers have and may continue to pay for these services under the Medicare physician fee schedule.

***Background***

The purpose of this CR is to incorporate in the *Medicare Claims Processing Manual* the payment policy and claims processing instructions previously included in Transmittal 129, CR 3631 (2005 Drug Administration Coding Revisions) issued on December 10, 2004, and Transmittal 148, CR3818 (Revised Coding Guidelines for Drug Administration Codes), issued on April 15, 2005.

***Implementation***

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

***Additional Information***

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

http://www.cms.hhs.gov/Transmittals/downloads/R968CP.pdf

The address for Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Section 30.5 (Internet Only Manual), is available on the CMS web site at:

http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

Transmittal 129, CR3631 (2005 Drug Administration Coding Revisions), issued on December 10, 2004, may be viewed on the CMS web site at:

http://new.cms.hhs.gov/transmittals/Downloads/R129OTN.pdf

The MLN article MM3631 may be viewed on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3631.pdf

Transmittal 148, CR 3818 (Revised Coding Guidelines for Drug Administration Codes) issued on April 15, 2005, may be viewed on the CMS web site at:

http://new.cms.hhs.gov/Transmittals/downloads/R148OTN.pdf

The MLN article MM3818 may be viewed on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3818.pdf

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

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

## New EMC Edits Effective July 3, 2006

*Reference: CR4064; LA – FM 060606*

The following new EMC pre-pass edits will be effective July 3, 2006:

Pre-pass edit M313 will reject claims that contain a value of J1 in the Procedure Modifier fields 2400/SV101-3, SV101-4, SV101-5 or SV101-6 when the Prescription Number field 2410/REF02 is not present (where 2410/REF01 is equal to XZ).

Pre-pass edit M361 will reject claims where 2410/REF01 equals XZ and 2410/REF02 is present and there is no Product or Service ID Qualifier field 2410/LIN02 with the value of N4.

J1 (above) is a new modifier code for Competitive Acquisition Program (CAP) claims. Please refer to the MLN Matters article MM4064 for details concerning the CAP.

## Electrical Stimulation – Manual or Unattended (Are you using the correct code?)

*Reference: MO – LSB 060106*

According to the CPT® and HCPCS code books, there are two types of electrical stimulation:

- HCPCS G0283 - Electrical Stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.
  *Health Care Procedure Coding System* © 2005 Practice Management Information Corporation. All Rights Reserved.
- CPT 97032 - Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes.
  *Current Procedural Terminology* © 2005 American Medical Association. All Rights Reserved.

**Unattended** electrical stimulation (HCPCS G0283) is a ***supervised modality*** which does not require direct (one-on-one) patient contact by the supplier (provider) during the entire episode of care. It is applied by the therapist initially and removed by the therapist when the treatment has been completed. It is **directly supervised** by the therapist in that he/she is present in the office suite, and readily available if needed. There is no time frame associated with this code.

**Manual** electrical stimulation (CPT 97032) is a ***constant attendance modality***, which means that the application of this modality requires **direct, one-on-one patient contact** by the supplier (provider) of service for the time that the treatment was provided, as indicated in the documentation.

Although manual electrical stimulation is provided by therapists, in the clinic setting unattended electrical stimulation is most often utilized, according to the suppliers attending seminars in all six states (listed below) of the Pinnacle Business Solutions Inc. Medicare coverage area.

When statistical analysis was performed for each of the states in the coverage area, it was noted that **97032 (manual electrical stimulation)** was always in the **top ten** allowed services provided by any supplier (provider) billing therapy codes, and **G0283** (unattended electrical stimulation) **never made the top ten**. This seems contradictory to general practice as noted above. The following is the breakdown for each state:

- In Arkansas, 97032 was 5th in allowed services
- In Louisiana, 97032 was 7th in allowed services
- In Missouri, 97032 was 7th in allowed services
- In New Mexico, 97032 was 5th in allowed services
- In Oklahoma, 97032 was 3rd in allowed services
- In Rhode Island, 97032 was 6th in allowed services

As your Medicare Carrier, we are required to make sure that you are providing our beneficiaries with the services you are coding and billing. As suppliers of service, Medicare requires that you bill the correct CPT code for the services you are providing and that there is documentation in your medical record to substantiate that claim.

If you are providing unattended electrical stimulation, please bill G0283; and if you are providing attended electrical stimulation, please bill 97032.

CPT® is a trademark of the American Medical Association.

# Incorrect Coding for Emergency Department E&M Services (CPT 99281-99285)

*Reference: MO –LSB 061506*

Review of national data for July through December 2005 revealed that one or more specialties in the Pinnacle Business Solutions, Inc. (PBSI) Medicare coverage area exceed the nation in allowed services per 1000 beneficiaries for the use of Emergency Department (ED) Evaluation and Management (E&M) codes (CPT® 99281-99285). This is especially true for the physician specialties of Family Practice (Specialty 08) and Internal Medicine (Specialty 11).

The Comprehensive Error Rate Testing (**CERT**) program also identified errors relating to Emergency Department Evaluation and Management services. The majority of these errors were due to **"incorrect coding",** which resulted in down coding of the services to a lower level when 1995 and/or 1997 **E&M Documentation Guidelines** were applied.

The emergency department is defined as an organized, hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention. It must be available 24 hours per day. Any physician seeing a patient registered in the emergency department may use emergency department visit codes. It is not required that the physician be assigned to the emergency department.

Medicare does not pay for any services which "*are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member*" per Title XVIII, Section 1862 (a)(1)(A) of the Social Security Act. Emergency Department Evaluation and Management services should be based on the **nature of the presenting problem and clinical judgment** of the physician, **to determine the medical necessity of the service and the level of the three key components** required. No distinction is made between new and established patients in the emergency room.

The nature of the presenting problem and key components for each level of E&M service are defined in the CPT Manual. A detailed explanation of the key components of E&M codes are found in the 1995 and 1997 Evaluation and Management Guidelines (see references).

Usual presenting problems per 2006 CPT Manual:

- 99281 – Self limited or minor
- 99282 – Low to moderate severity
- 99283 – Moderate severity
- 99284 – High severity, and require **urgent evaluation** by the physician, but **do not** pose an immediate, significant threat to life or physiologic function
- 99285 – High severity, and **pose an immediate, significant threat** to life or physiologic function

Not all services provided in the emergency department are emergencies. Often patients come into the emergency department with lower level problems due to lack of an attending physician or the fact that their physician is not available at that time. However, if they are registered and treated in the emergency room, their visit should be billed under the appropriate emergency room codes, depending on the nature of their presenting problem. Normally a lower level emergency department code would be reported for a non-emergency condition.

Examples of situations involving ED visits and other E&M codes are as follows:

- The patient may call his/her physician after hours and the physician may ask the patient to meet him/her in the emergency department. The patient is not registered. The physician sees the patient. The physician would charge the appropriate Office or Other Outpatient Services Evaluation and Management code for the visit.
- The emergency department physician might request that another physician evaluate a patient. If the criteria for a consultation are met, the physician would bill an Outpatient Consultation code for his/her visit. If they are not met and the physician admits the patient to the hospital, he/she would charge only an Inpatient Hospital Care code, and the ED visit would be included in the admission code. If the criteria are not met and the patient is discharged from the ED, he/she would bill an ED Evaluation and Management code, as would the emergency room physician.
- The patient's personal physician might come to the emergency department to see the patient. If he/she sends the patient home, both the ED physician and the patient's personal physician bill the Emergency Department codes. The patient's personal physician would not bill a consultation because he or she is not

providing information to the emergency department physician for his or her use in treating the patient. If he/she admits the patient, the ED physician would bill the ED codes and the personal physician would bill only the Initial Hospital Care code because all evaluation and management services provided in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.

- Ø If an emergency department visit is provided on the same date by the same physician as an Initial Nursing Facility visit, the emergency department visit by that physician would not be paid. Payment for E&M services provided in sites other than the nursing facility is included in the payment for Initial Nursing Facility Care when performed on the same date as the nursing facility admission by the same physician.
- Ø If the patient's personal physician is called by the emergency room physician and does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill Medicare for any Evaluation and Management service.

For any Evaluation and Management service, **documentation is the key to payment**, but the documentation must be at the appropriate level. The **amount and level of documentation** of the **three key components** (history, examination, and medical decision making) should be **based on the nature of the presenting problem** and **clinical judgment of the physician**.

- Ø If the presenting problem is of low severity, requiring a documentation level of 99282 (such as an emergency department visit for a patient presenting with a rash on both legs after exposure to poison ivy), key components of history and examination would be expanded problem focused and only a low complexity level of decision making would be required.
- Ø If the presenting problem is of high severity requiring a documentation level of 99285 (such as an emergency department visit for a patient with an acute onset of chest pain compatible with symptoms of cardiac ischemia and/or pulmonary embolus), it would be expected that the physician would document a comprehensive history, comprehensive examination, and a high level of decision making. (Additional examples of Emergency Department Evaluation and Management for each level of service can be found in Appendix C of the CPT manual.)

Most of the CERT errors were at the very highest level codes, where documentation did not support a comprehensive history, comprehensive exam, and medical decision making of high complexity. For one service, the level coded was 99284, but (other than reviewing the vital signs) only a nursing assessment/exam was performed based on the documentation submitted. The exam portion of the ED record for the physician was blank. This service had to be down coded to a 99281, as it did not meet the guidelines of 3 of 3 key elements.

When a service is down-coded by CERT, the Medicare contractor is required to collect overpayment for the difference between the fee for the higher code that was paid and the fee for the lower code identified as being correct. **It is therefore imperative that physicians are cognizant of these coding problems and correctly code their visits.**

We ask that all physicians that bill Emergency Department Evaluation and Management codes:

- Review the 1995 and 1997 Evaluation and Management Guidelines.
- Review the Emergency Department Section of the CPT coding book.
- Think about the nature of the presenting problem and the medical necessity for treating each patient when performing and documenting a particular level of service.
- If the Medicare Contractor or CERT requests medical records, please include all documentation for the services provided for that date.
- REMEMBER that documentation must support the level of service billed.

**References:**

1. Title XVIII of the *Social Security Act*, Section 1862(a)(1)(A).
2. *Current Procedural Terminology* ©2005 American Medical Association. All rights reserved. CPT® is a trademark of the American Medical Association.
3. *1995 and 1997 Evaluation and Management Documentation Guidelines* available on the CMS website at www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp
4. *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.11 available on the CMS website at www.cms.hhs.gov/Manuals/
5. CERT information may be found at www.certprovider.org

## Requirements for Referring Providers - Laboratory Services

*Reference: MO –LSB 061506*

As your Medicare Carrier, we have noticed a significant problem regarding medical necessity denials for laboratory services due to incorrect diagnoses. Title XVIII, Section 1862 (a)(1)(A), of the Social Security Act states that Medicare will not pay for any services which *"are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."* Laboratories are dependent upon the referring physician to obtain medically necessary diagnoses for the laboratory tests they perform. We are asking you to help us with this dilemma.

Physicians should know there are laboratory National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) regarding laboratory services with allowable diagnoses, and they need to review these whenever a laboratory service is requested. (Please note that NCDs are updated quarterly and posted on the CMS website). If the diagnosis provided is not listed, there is often another diagnosis that is applicable, or there are signs and symptoms in the physician's documentation that provide medical necessity for the test, which should be utilized by the physician in his/her referral. If neither the diagnosis or the signs and symptoms warrant the test per the NCDs or LCDs, the physician should then (and only then) provide the patient with an Advanced Beneficiary Notice (ABN) to sign prior to the test, that assigns the liability for payment to the patient.

The main problem we are seeing as a Carrier is that frequently, patients are requested to sign an ABN for test(s) that may or may not be payable by Medicare. This may result in <u>unnecessary liability for the patient.</u> Physicians, or their staff, often assign the ICD-9 codes based on the "superbill", on which they list only the reason for the <u>visit</u>, not the <u>reason for the actual test</u>. **The physician should link the medically necessary diagnosis to the lab test** so that the correct information is placed on the laboratory requisition forms. Many times Medicare would pay for the service, if a covered diagnosis (which should be documented in the patient's medical record) is submitted on the claim.

Many laboratories never see the patient, as the specimen collection is performed in the physician office. If the physician does not give the patient an ABN and the test is non-covered, the laboratory must either call the physician prior to running the test (which could cause a delay of the test results and delay in treatment of the patient), or assume the liability themselves, which is unfair to the laboratory.

If the patient comes to the laboratory for a test with a diagnosis that is not covered according to the LCD's or NCD's, the laboratory has to do one of the following:

- Give the patient an ABN for a test that perhaps could have been paid by Medicare if the physician reviewed the policies and applied the correct diagnosis;
- Not provide the test until they get an answer from the physician regarding the diagnosis; or
- Assume liability for the test.

The Medicare law is clear. Section 4317(b) of the Balanced Budget Act (BBA) <u>requires</u> that physicians and practitioners provide diagnostic information when ordering certain items or services furnished by another entity. As specified in Section 1861(s) of the Social Security act, this includes diagnostic laboratory tests and other diagnostic tests. Per Section 1842 (p)(4), the information must be provided to the entity which will actually provide the services <u>at the time the item or service is ordered by the physician</u>. The provision of this diagnostic information serves as a condition for payment.

In the OIG Model Compliance Plan for Laboratories it states: "the OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law." This applies to physicians who order medically unnecessary tests for which Medicare reimbursement is claimed.

Laboratory denials due to medical necessity are <u>preventable.</u> The ordering or referring physician must take responsibility to make sure that he/she assigns the <u>correct diagnosis</u> <u>for each individual test ordered</u>. The physician and/or the staff must ensure that the limited diagnosis policies are reviewed prior to sending the patient for a test or performing a specimen collection. They must ensure that they only give ABNs for <u>specific tests</u> that do not meet the criteria due to frequency, screening, or other constraints, so that their patients are not ultimately liable for tests which Medicare would ordinarily pay. Blanket ABNs for all tests performed on a particular date should never be given. Per the Claims Processing Manual cited below, "*A physician or supplier should not give an ABN to a*

*beneficiary unless the physician or supplier has some genuine doubt regarding the likelihood of Medicare payment as evidenced by its stated reasons. Giving ABNS for all claims or items or services (i.e.,'blanket ABNs') is not an acceptable practice. Notice must be given to a beneficiary on the basis of a genuine judgment about the likelihood of Medicare payment for that individual's claim."*

Referring physicians have a responsibility to understand the medical necessity of the services they order. They have a responsibility to their patients to see that they are not made liable for payable services under the Medicare law. Lastly, they have a responsibility to the laboratories that provide the service to their patients to insure they have a billable diagnosis or a viable ABN for the services they bill. Please take this responsibility seriously. Look at your ordering/referring policies and processes to make sure all of these things are taken into consideration.

**References:**


1. Claims Processing Manual, Chapter 30, Section 40.3.6.2 - Blanket ABNs.
2. Title XVIII of the Social Security Act, Section 1862 (a)(1)(A) - Medical Necessity
3. Title XVIII of the Social Security Act, Section 1861 (s) and Section 1842 (p)(4) - definition of services and exclusion from coverage respectively.
4. OIG Compliance Program Guidance for Clinical Laboratories, Federal Register/ Vol. 63, No. 163/Monday, August 24, 1998/Notices, Compliance Program Elements (A)(1)(b).
5. Balanced Budget Act of 1997, Chapter 2, Section 4317 - Requirement to Furnish Diagnostic Information.
6. National Coverage Determination for Laboratories may be found at the following website: www.cms.hhs.gov/mcd/index_section.asp?ncd_section=40
7. Local Coverage Determinations may be found on our local websites under Final Local Coverage Determinations

## Multiple Endoscopies Billing Clarification

*Reference: LA –DJL 061906*

We received a question regarding billing for multiple endoscopies in the same family on the same date of service.

Please refer to your state web site in the Provider Information area under Publications, Newsletters. The specific newsletter to review would be **Indicators/Global Surgery Percentages/Endoscopies: Attachment C**. Page two of Attachment C states the following:

**Medicare Fee Schedule Data Base Endoscopy Codes for 2006**

- Special pricing rules apply to multiple endoscopies.
- Endoscopies are grouped into "families" with the same base procedures.
- If multiple related endoscopies are performed, payment is based on 100 percent of the highest valued endoscopy, plus the difference between the next highest valued endoscopy and the base endoscopy. For example:

  In the course of performing a fiberoptic colonoscopy (code 45378), a physician performs a biopsy on a lesion (45380) and removes a polyp (45385). The value of codes 45380 and 45385 both have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), Medicarewill pay the full value of the higher valued endoscopy (45385) plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378). Assume the following are the fee schedule allowables for these codes (check your fee schedule for your actual amounts):

  45378 - $266.48

  45380 - $291.97

  45385 - $387.090

  Medicare will approve payment for the full value of 45385 ($387.90) plus the difference between 45380 and 45378 ($25.49) for a total of $413.39. The limiting charge is 115 percent of the approved amount for each procedure. Therefore, the limiting charge for 45385 would be $446.09 ($387.90 x 115 percent) and the limiting charge for 45380 would be $29.31 ($25.49 x 115 percent). The total limiting charge on the claim would be $475.40 ($446.09 + $29.31).

  Code 45378 should not be billed because it is included in the description for code 45380.
- A listing of procedures affected by the endoscopic multiple surgery guidelines is included in Attachment C. The multiple surgery indicators for each procedure are listed in Column M of Attachment A. Also included in Attachment C is the list of endoscopy families and the base code for each family.

Appending a 59 modifier to the endoscopic procedures in the same family would be appropriate.

Appending a 51 modifier to an endoscopic procedure not in the same family would be appropriate.

## Reciprocal Billing/ Locum Tenens Arrangements and Use of Q5 and Q6 Modifiers

*Reference: MO – LSB 061906*

The Q5 Modifier is utilized for payment for physician claims submitted to carriers under Reciprocal Billing Arrangements; while the Q6 Modifier is utilized for physician payment for claims submitted to carriers under Locum Tenens Arrangements. Recent trends in utilization have shown **potential misuse of these modifiers in all six states** in which Pinnacle Business Solutions is the Medicare carrier. We are therefore providing a review of the coverage for each of these situations to enable physicians and physician groups to take immediate steps to correct their billing practices, if necessary.

The name and identification number placed on the billing form represents the personal identity of the provider to whom it is assigned. **Knowingly misusing a provider's name and/or identification number can constitute fraud!**

There are two types of circumstances in which the regular provider utilizes the services of another provider and bills under the regular provider's name and number: These include Reciprocal Billing Arrangements and Locum Tenens Arrangements:

- Reciprocal Billing Arrangements - There is no need for an employer/employee relationship to exist. This is an arrangement of a substitute physician covering for another physician on an occasional basis. The substitute physician in this type of arrangement usually has a practice of his/her own and is properly enrolled as a Medicare provider. There is no mention of the regular physician paying the substitute physician.
- Locum Tenens Arrangement – This type of arrangement may exist when a physician generally has no practice of his/her own. He/she usually moves from one area to another area as needed to cover for an unexpected or planned absence of a regular physician. The regular physician usually pays the Locum Tenens physician a fixed amount per day or fee for time basis as an independent contractor, rather than as an employee.

**Reciprocal Billing** Arrangements – Use of the **Q5 Modifier**

Four Situations – Similar Rules:

- A patient's regular physician submits the claim and receives Part B payment for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis.
- A medical group submits claims for the covered visit services of a substitute physician who is **not** a member of the group.
- An independent physician submits claims for the substitution services of a physician who **is** a member of a medical group.
- A group member provides services related to a hospice patient's terminal illness on behalf of another group member who is the designated attending physician for the hospice patient.

The following **requirements must be met** in each of the above situations:

- **The regular physician is unavailable to provide the visit services;**
- The Medicare patient has arranged or seeks to receive these services from the regular physician; and
- The substitute physician does not provide the services to Medicare patients over a continuous period of longer than 60 days.

If a line item includes the modifier Q5 certification, carriers should be able to assume that the claim meets the requirements of the above section in the absence of evidence to the contrary**. Penalty for false certifications may be civil or criminal penalties for fraud.**

Payment under **Locum Tenens** Arrangements – Use of the **Q6 Modifier**

The phrase *locum tenens* means "stands in the shoes of or substitutes for." This situation is commonly utilized **when physicians or physician groups retain substitute physicians to take over their professional practices when the regular physician is absent** due to illness, pregnancy, vacation, or continuing medical education. The locum tenens physician is generally a physician without a practice of his/her own who moves from area to area, or

practice to practice as needed. They are paid a fixed amount per diem as an independent contractor. The regular physician may be of any specialty.

Three Situations – Similar Rules:

- A patient's regular physician submits a claim and receives Part B payment for covered visit services (including emergency visits and related services) of a locum tenens physician, who is not his/her employee and whose services are not restricted to this particular physician's office(s).
- A medical group submits claims and receives Part B payment for covered services of the locum tenens physician, who is not a member of the group and who is paid on a per diem basis.
- A medical group submits claims and receives Part B payment for covered services of the locum tenens physician as a temporary replacement for a physician who has left the group.

The following **requirements must be met** in each of the above situations:

- **The regular physician is unavailable to provide the visit services;**
- The Medicare beneficiary has arranged or seeks to receive these services from the regular physician;
- The regular physician or group pays the locum tenens for his/her services on a per diem or similar fee-for-time basis; and
- The substitute physician does not provide the services to Medicare patients over a continuous period of longer than 60 days.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

Problems Noted by the Carrier

- One problem noted with the usage of these modifiers occurs when **the patient's regular physician or provider performs and bills** for **other services on the same date he/she is billing services with the Q5 and Q6 modifiers**. As stated above, the use of the modifier is only allowed when the regular physician is **unavailable** to provide the visit services. If they are billing other services on that date, it is obvious that they were available and are utilizing the modifiers incorrectly.

  The charts below are for the time period of July through December 2005. They show the total **allowed amounts** billed by the patients' regular physician **with** these two modifiers, for services performed by another physician, **on the same date** as other services the regular physician performed **without** the modifiers. Chart # 1 shows the **combined amounts** of the two services, demonstrating the duplicity of billing that would not take place if the regular physician was truly absent from the practice. When the payments from Chart # 2 and Chart # 3 are combined, you can see that these improper claims involve **significant dollar amounts** paid to physicians that **should not have been paid by Medicare**.

  Chart # 2 and Chart # 3 show the allowed amounts separately billed by the regular physician for his services and for the services of either the substitute or locum tenens physician on the same date.

  Modifier Q6 is used significantly more than Q5 across all six states.

**Chart # 1**

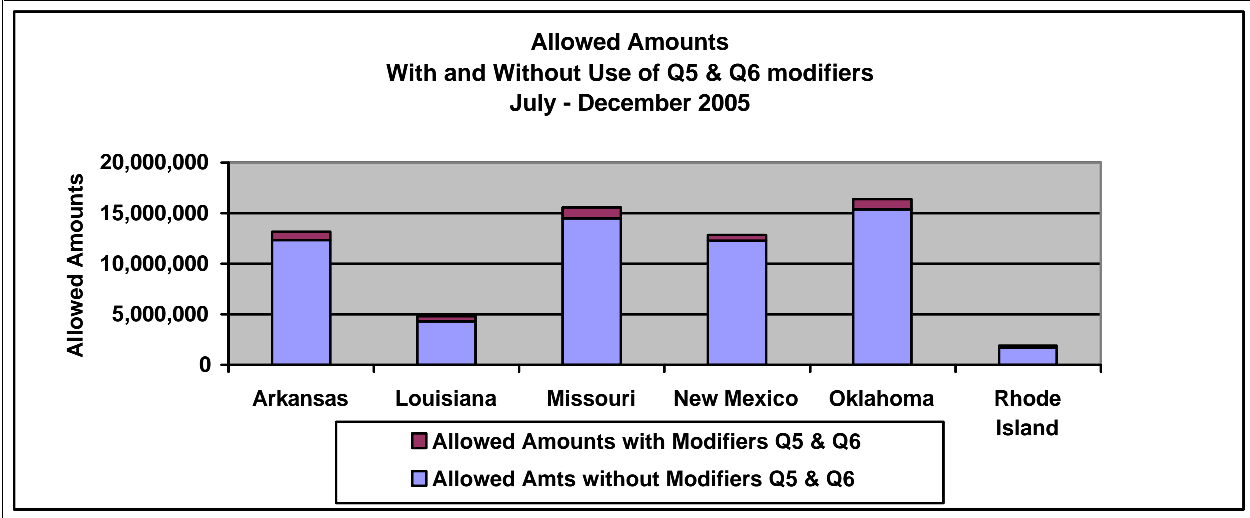



**Chart # 2**

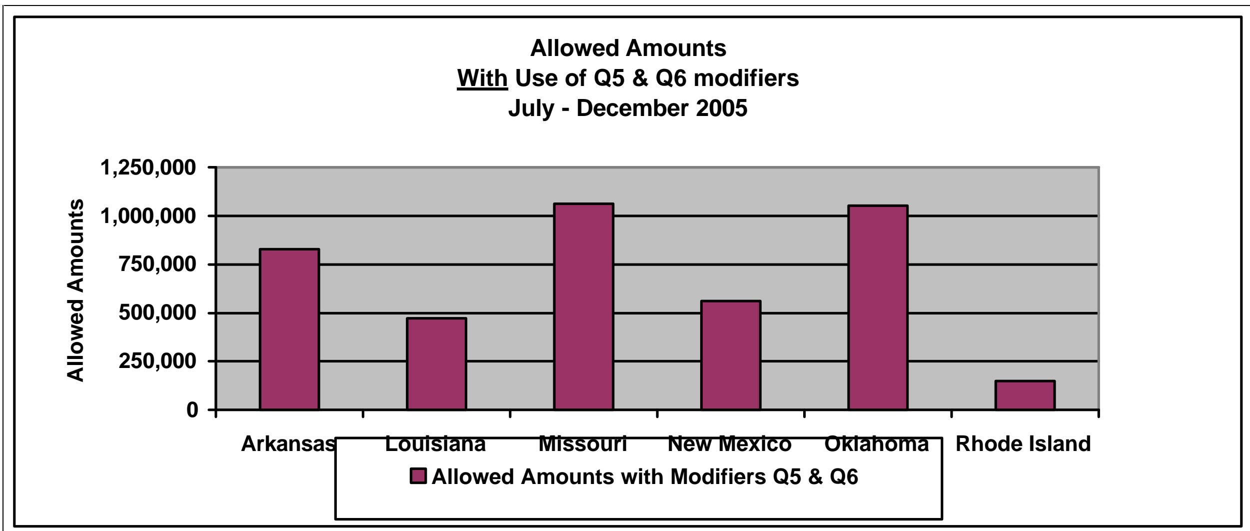
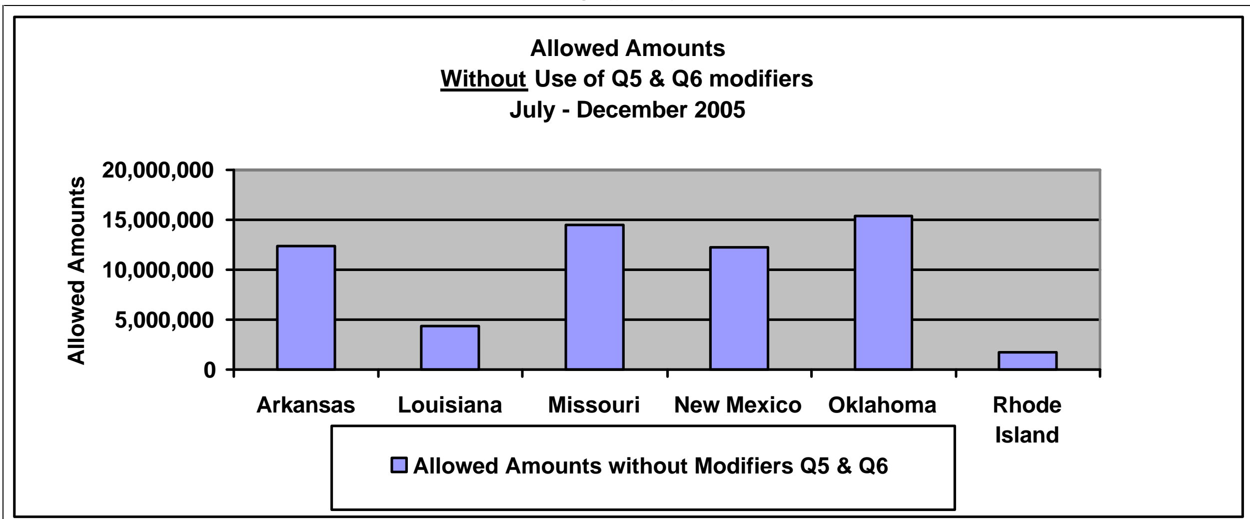



**Chart # 3**



- The second problem noted by the carrier is that when physicians send in their documentation for medical review, **the reviewers are unable to identify which provider is the locum tenens** physician. This is especially true in the case in which there are several specialists seeing the patient in addition to the locum tenens physician (as in a hospital setting). The manual requires that a record of each service provided by the substitute physician for either an independent physician or a group must be kept on file and associated with the substitute physician's UPIN. This record must be made available to the carrier upon request.

**In order to perform medical review, the carrier must have sufficient information to establish clearly that a service qualifies to receive payment. The name and UPIN of the performing provider must be placed in box 19 of the CMS 1500 form when modifier Q5 or Q6 is used. This will clearly identify the performing provider to a medical reviewer, if needed.**

The Medicare manual states for use of modifier Q5, "For the group, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) on block 24K of the appropriate line item."

CMS has entrusted the carriers to safeguard the Medicare Trust Fund. We cannot do that without your help. Physicians must be careful to follow all of the guidelines in the CMS Manuals as well as national and local policies. **The entity billing and receiving payment and the person reassigning his or her billing/payment rights are both responsible for compliance with the program integrity safeguards and all of the rules noted above**.

**References:**

- Publication 100-4 *Medicare Claims Processing Manual*, Chapter 1, Sections 30.2.10 and 30.2.11.
- Change request 3628, Transmittal 472
- 42 CFR Ch. IV (10-1-03 Edition) Sections 411.350 and 411.351

## July Update to the 2006 Medicare Physician Fee Schedule Database

*Reference: Trans. 963, CR #5102, Pub. 100-04, Medlearn Matters Number: MM5102*

***Provider Types Affected***

Physicians, providers, suppliers submitting claims to carriers or fiscal intermediaries (FIs) for services paid under the Medicare Physician Fee Schedule (MPFS) provided to Medicare beneficiaries.

***Impact on Providers***

This article is based on Change Request (CR) 5102, which amends payment files issued to your carrier/intermediary that were based on the November 21, 2005, MPFS Final Rule. Attachment 1 of CR5102 also includes new Category II and Category III codes.

***Background***

The Social Security Act (Section 1848(c)(4); http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Change Request (CR) 5102:

- Amends payment files issued to your carrier/intermediary based upon the November 21, 2005, Medicare Physician Fee Schedule (MPFS) Final Rule; and
- Includes new Category II and Category III codes.

CR5102 also instructs that your carrier/intermediary should:

- Give providers 30 days notice before implementing the revised payment amounts identified in CR 5102 (Attachment 1) in accordance with the Medicare Claims Processing Manual (Pub 100-4, Chapter 23, Section 30.1; http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf). Note that unless otherwise stated in CR5102, changes will be retroactive to January 1, 2006;
- Not search their files to either retract payment for claims already paid or to retroactively pay claims; and
- Adjust claims brought to their attention.

Changes included in the July Update to the 2006 MPFS Database (CR5102 (Attachment 1)) are as follows:

| Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Code | ACTION |
|---|---|
| 95991 | Non-Facility RVU = 1.50 |
| G0978 | Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 *or t3a†* gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases |
| G9125 | Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; *blast phase not†* in hematologic, cytogenetic, or molecular remission |
| G9127 | Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; extent of disease unknown, under evaluation, not listed (for use in a Medicare-approved demonstration project) |

In addition, effective July 1, 2006, a number of **Category II codes** will be added to the MPFSDB with a status indicator of "M". Rather than repeat all those Category II codes in this article, we refer you to Attachment 1 of CR5102, which contains the codes and their descriptors. CR5102 is available on the CMS web site at:

http://www.cms.hhs.gov/Transmittals/downloads/R963CP.pdf

The long descriptor for **Category II code 1000F** has been revised. **The new descriptor is effective for services performed on or after January 1, 2005** (date code was implemented).

| Category II Code | 1000F |
|---|---|
| **Long Descriptor:** | Tobacco use assessed (CAD1, CAP1, COPD1, DM4, PV1) |

The descriptors for Category II code 4015F have been revised. The new descriptors are effective for services performed on or after January 1, 2006 (date code was implemented).

| Category II Code | 4015F |
|---|---|
| **Long Descriptor (Revised):** | Persistent asthma, preferred long term control medication or acceptable alternative treatment, prescribed (Asthma1) |
| **Short Descriptor** | Persist asthma medicine ctrl |

Also, note that G code (G8085) was inadvertently not included in the April update. G8085 is added with a status indicator of "M" and is effective for services on or after January 1, 2006. The long descriptor for G8085 is "End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula."

Effective July 1, 2006, the Category III codes of 0155T-0161T will be added to the MPFSDB. The descriptors and other indicators for these codes may also be found in Attachment 1 of CR5102.

***Implementation***

The implementation date for CR5102 is July 3, 2006

***Additional Information***

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

http://www.cms.hhs.gov/Transmittals/downloads/R963CP.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

## New Medicare Secondary Payer (MSP) Balancing Edits

*Reference: CR4261*

***Note: This article is a correction to the article published on page 52 of the May 2006 Medicare Provider Newsletter.***

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/SVD02 + 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/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.

## Modifications to Online Medicare Secondary Payer Questionnaire: This CR Rescinds and Replaces CR4098

*Reference: Trans. 53, CR #5087, Pub. 100-05, Medlearn Matters Number: MM5087*

***Provider Types Affected***

Medicare physicians/providers/suppliers that, upon providing services to a Medicare patient, use a questionnaire to determine other insurance coverage that may be primary to Medicare

***Impact to You***

Questions have arisen over Part V of the model Medicare Secondary Payer Questionnaire.

***What You Need to Know***

CR5087 provides clarification regarding Part V, provides major revisions to other parts of the model Medicare Secondary Payer Questionnaire, and rescinds and replaces CR4098.

***What You Need to Do***

You should replace any previous versions of the model questionnaire with the new version, available as an attachment to CR5087.

***Background***

In 1980, Congress enacted provisions that made Medicare the secondary payer to certain additional primary plans (group health plans, workers' compensation plans, liability insurance, or no-fault insurance). To help you identify such Medicare Secondary Payer (MSP) situations, CMS has developed a model Medicare Secondary Payer Questionnaire (found in IOM 100.05 (Medicare Secondary Payer Manual) Chapter 3, Section 20.2.1). You can use this model questionnaire as a guide, at each inpatient and outpatient admission, to help identify other payers that may be primary to Medicare.

CR4098 (released October 21, 2005) made changes to this model questionnaire that have generated several questions, specifically regarding PART V (Disability). In response, CR 5087 (from which this article is taken) incorporates the changes that were made in CR 4098, modifies the changes previously made to PART V to address the questions that have arisen, and makes additional changes to other parts of the model questionnaire to improve the wording and sequencing of questions in these parts.

The changes to the model questionnaire are too numerous to list here. As such, please refer directly to the revised section in the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete, updated model questionnaire. The changes are identified in redline and italics.

Please keep in mind the following:

1. This questionnaire is a model. Other questions may be added to help identify other payers that may be primary to Medicare.
2. If you choose to use this model questionnaire, please be aware that it was developed to be used in sequence. The Instructions listed after the questions are to direct the patient to the next appropriate question to facilitate transition between questions.

***Additional Information***

You can find more information about the Medicare Secondary Payer Questionnaire by viewing CR5087 at:

http://www.cms.hhs.gov/Transmittals/downloads/R53MSP.pdf

Attached to the CR is the revised section of the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete, updated model questionnaire.

If you have any questions, please contact your carrier (including durable medical equipment regional carrier), fiscal intermediary, or regional home health 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 Summary Notice (MSN)

## Quarterly Medicare Summary Notice (MSN) Printing Cycle

*Reference: Trans. 955, CR #5062, Pub. 100-04, Medlearn Matters Number: MM5062*

**Note:** This article was revised on May 24, 2006, to correct the implementation date for DMERCs. That date should have been July 3, 2006. The transmittal number also changed, since Transmittal R945 (dated May 12, 2006) was rescinded and replaced with Transmittal R955 (dated May 19, 2006). All other information remains the same.

***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 3, 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/R955CP.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

## 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 – FM 061606*

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. 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.

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 NNNNNNNNN, 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 NNNNNNNNN, NN-NNNNNNN or NN(space)NNNNNNN.

| Edit Number | Loop |
|---|---|
| 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.

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.

M371 2420C
M378 2310D

---

## Reminder to Enumerate; Countdown Has Begun

*Reference: JSM CI 3974-06468, 05-30-06*

Countdown has begun; do you have your NPI? Don't risk disruption to your cash flow – Get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website.

This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

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

## Payment for Positron Emission Tomography Scans in CMS-Approved Clinical Trials and Coverage with Evidence Development - Use of QR and QV Modifiers

*Reference: Trans. 956, CR #5124, Pub. 100-04, Medlearn Matters Number: MM5124*

***Provider Types Affected***

Physicians and other providers who bill Medicare carriers and fiscal intermediaries (FI) for the use of FDG PET scans for oncology and dementia/neurodegenerative diseases

***Impact to You***

Effective January 28, 2005, for certain FDG PET indications (listed in the *Background* section below), rather than the **QV** modifier previously required, you must use the **QR** modifier on all carrier claims to identify that this service is provided in a Medicare-specified study.

***What You Need to Know***

CR5124 revises Transmittal 527 (CR 3741) to require that you use the appropriate CPT code and the **QR** modifier (item or service provided in a Medicare-specified study), rather than the **QV** modifier (other than inpatient), on carrier claims for services for dementia and neurodegenerative diseases, and a broad range of cancer indications listed as "coverage with evidence development."

Claims submitted to FIs must contain the principal diagnosis code, the appropriate CPT code, and V70.7 diagnosis code. In addition, CMS has entered into an agreement with the Academy of Molecular Imaging (AMI) in which AMI collects data for a broad range of cancers through the National Oncologic PET Registry (NOPR). The NOPR, which began accepting patients on May 8, 2006, satisfies Medicare's requirement that the FDG PET provider and Medicare beneficiary participate in a prospective clinical study in order for the services to be considered reasonable and necessary. NOPR information and registration materials are available at its website, provided in the *Additional Information* section below.

***What You Need to Do***

Make sure that your billing staffs are aware of these coding changes for FDG PET services in your Medicare claims.

***Background***

**Positron Emission Tomography (PET)**

Positron Emission Tomography (PET) is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images obtained by detecting radioactivity from a radioactive tracer substance (radionuclide), 2-[F-18] Fluoro-D-Glucose (FDG).

Refer to Publication 100-03, the *National Coverage Determinations (NCD) Manual*, section 220.6, for coverage instructions that indicate conditions under which a PET scan is performed. The manual is available on the CMS web site at:

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

**Covered FDG PET Scans**

For cancers listed as "coverage with evidence development" in section 220.6 of the NCD Manual, CMS has determined that (effective for services performed on or after January 28, 2005) FDG PET scans are reasonable and necessary only when the provider is participating in, and patients are enrolled in:

- A clinical trial that meets the requirements of Food and Drug Administration (FDA) category B investigational device exemption (42 CFR 405.201); or
- An FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management.

CR3741, released April 15, 2005, indicated that there is adequate evidence to conclude that an FDG PET scan for the detection of pre-treatment metastases (i.e., staging) in newly-diagnosed cervical cancer (after conventional

imaging that is negative for extra-pelvic metastasis), is reasonable and necessary as an adjunct test, and it expanded coverage to include FDG PET for certain indications of cervical cancer.

CR3741 also designated **QV** as the correct modifier to be used in carrier claims for beneficiaries participating in CMS-approved clinical trials utilizing FDG PET scans for dementia and neurodegenerative diseases.

CR5124, upon which this article is based, revises CR3741 to provide that (effective for services on or after January 28, 2005) you will be reimbursed for the use of FDG PET services for:

- Dementia and neurodegenerative disease (see NCD Manual (100.03) section 220.6.13);
- Certain indications for cancers of the cervix, lung (including small cell), esophagus, colon and rectum, head and neck, breast, thyroid, brain, ovary, pancreas, and testes; and lymphoma, melanoma, and soft tissue sarcoma (as listed in sections 220.6.2-220.6.7 and 220.6.10-220.6.14); and
- All other cancer indications not previously specified (as listed in section 220.6.15);
- **Only** if these scans were performed as part of a Centers for Medicare & Medicaid Services (CMS)-approved clinical trial.

In fact, be aware that FDG PET scans for all cancer indications listed in section 220.6 as "coverage with evidence development" remain nationally non-covered unless they are performed in conjunction with a CMS-approved clinical trial.

**Using Appropriate CPT Code and QR Modifier**

In line with the requirement for including these patients in clinical trials, you must submit all (other than inpatient) FDG PET claims to your carriers using the appropriate CPT code and the **QR** modifier, which was created for use on Part B claims (and other outpatient claims) to identify items/services that are covered when provided in a Medicare-specified study.

You may no longer use the **QV** modifier when a beneficiary undergoes an FDG PET scan in a facility participating in a Medicare-approved study specified by the above-referenced NCDs.

**National Oncologic PET Registry (NOPR)**

You should also be aware that CMS contracted with the Academy of Molecular Imaging (AMI) to establish the NOPR, a national, internet-based data registry that reports on oncologic FDG PET scans received by Medicare beneficiaries as outlined in the NCD.

Reporting data to the NOPR for the oncologic FDG PET scan indications listed in section 220.6 as "coverage with evidence development" is a requirement of Medicare coverage. Without appropriately reported data, Medicare may be unable to approve claims and/or may be required to take action to recoup payments already made if data reporting discrepancies are discovered through post-payment claims analysis.

Remember that you are responsible for ensuring that data is accurately reported to the NOPR and that claims are accurately submitted. CMS recommends that you contact NOPR so that your facility may provide expanded oncologic FDG PET benefits under the NCD.

When submitting such claims to your FIs, you should use the appropriate principal diagnosis code, the appropriate CPT code, and ICD-9 code V70.7 in the second diagnosis position on the CMS-1450 (UB-92), or the electronic equivalent.

Finally, note that effective for PET scan claims with dates of service on or after January 28, 2005 until implementation of CR5124 on June 19, 2006, your carriers and FIs do not need to search their files to either retract erroneous payment for claims already paid or to retroactively pay claims incorrectly processed, unless you bring those claims to their attention.

***Additional Information***

You can find more information about FDG PET scans in patients undergoing Medicare approved clinical trials by going to CR5124, located on the CMS web site at:

http://www.cms.hhs.gov/Transmittals/downloads/R956CP.pdf

Additionally, you might want to look at the *National Coverage Determinations (NCD) Manual*, sections 220.6, 220.6.2 - 220.6.7, 220.6.10 - 220.6.12, 220.6.14, and 220.6.15 for important information regarding FDG PET for oncology.

The transmittal that conveyed the above NCD is available on the CMS web site at: http://www.cms.hhs.gov/Transmittals/downloads/R31NCD.pdf

A related Medicare Claims Processing Manual transmittal is available on the CMS web site at: http://www.cms.hhs.gov/Transmittals/downloads/R527CP.pdf

A related MLN Matters article appears on the CMS web site at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3741.pdf

Information and registration materials are available on NOPR's website at http://www.cancerPETregistry.org.

A regularly updated list of NOPR's Medicare approved facilities is located on the CMS web site at: http://www.cms.hhs.gov/MedicareApprovedFacilitie/NOPR/list.asp#TopOfPage

NOPR can also be reached at 800-227-5463, extension 4859, or 215-717-0859. If you have any questions, please contact your carrier or FI at their toll-free number, which may be found on the CMS web site at: http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf

# Provider Identification Number (PIN)

## Understanding Your Medicare Identification Numbers

*Reference: OK – LAL 061906*

Providers are not required by law to render services to Medicare beneficiaries. If a provider renders care to a Medicare beneficiary, the provider must have a Medicare Provider Identification Number (PIN) in order to submit claims for payment.

In some instances a provider may have several PINs. A separate PIN may have been assigned for each practice location of the provider. It is imperative that the appropriate PIN for the appropriate location is used.

When an inappropriate PIN is reported on a claim, it can result in payments to the wrong provider or inaccurate "tracking" reports/trend analysis by the Medicare carrier. When an incorrect PIN is identified, Medicare is required to collect the amount paid under the wrong PIN and reissue payment under the appropriate PIN. This results in additional paperwork and administrative costs for both the provider and Medicare.

**Where does the PIN belong on the claim?**

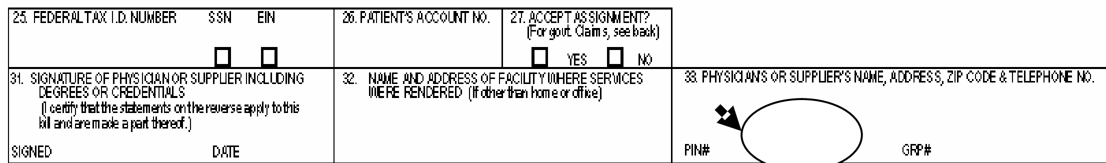
When billing for the services of a **solo practitioner**, the PIN should be reported in the following fields:

**CMS-1500 claim form**

Field 33, bottom left corner, next to PIN#

***Item 33***
Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.** For a provider who is **not** a member of a group practice (e.g., private practice), enter the PIN at the bottom of item 33 for paper claims. The PIN should be entered on the **left** side, next to the PIN# field.

**UPINs are not appropriate identifiers for item 33.**


25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. Claims, see back) YES NO
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
PIN# GRP#

***ELECTRONIC CLAIMS -*** When billing for the services of a **solo practitioner**, the PIN should be reported in the following fields.

**ANSI -** 2310B

Ref01=1C

Ref02=PIN#

**Group PIN**

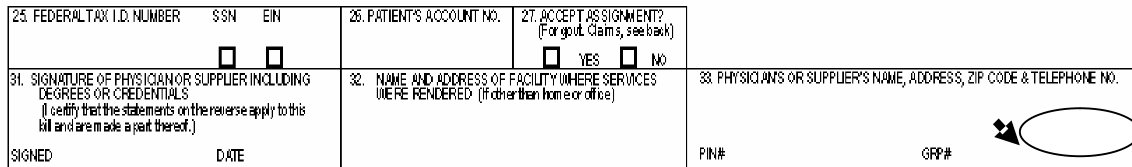
Providers in a Medicare approved group practice use **two** PIN numbers.

Group identification numbers (Group PINs) are assigned to clinics that may employ several physicians and non-physician practitioners. The group PIN should be reported in the following fields:

**CMS-1500 Claim Form:**

Field 33, bottom right corner, next to GRP#

***Item 33***
Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.** If a group practice is billing, then the **group PIN** is to be placed in item 33 for paper claims. Enter the group PIN at the bottom of item 33 on the **right** side, next to the GRP# field. *Enter the PIN for the performing provider of service/supplier who is a member of that group practice in item 24K.*



25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. Claims, see back) YES NO

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

PIN# GRP#

***ELECTRONIC CLAIMS -*** The Group PIN should be reported in the following fields.

**ANSI -** 2010AA

Ref01=1C

Ref02=Group PIN#

**Performing Physician's PIN**

The PIN of the appropriate physician and/or non-physician practitioner within the group that actually performed the service should be reported in the following fields:

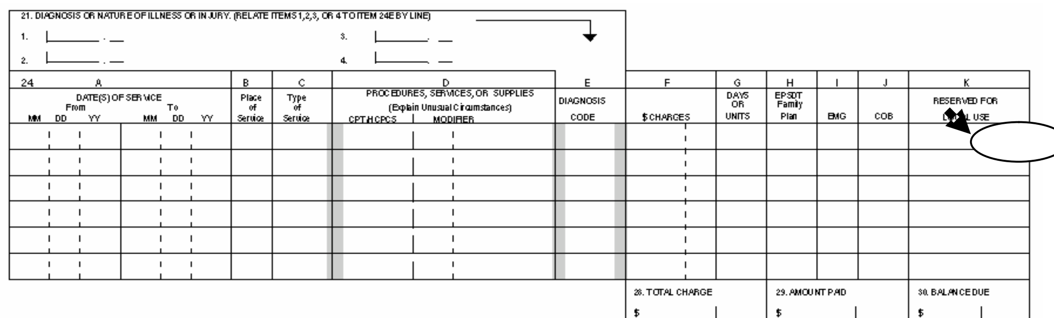
**CMS-1500 Claim Form**

Field 24K

***Item 24K***

Enter the **provider identification number (PIN)** of the performing provider of service/supplier in item 24K if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, or electronic equivalent, show the individual PIN of each performing provider in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24K.

**UPINs are not appropriate identifiers for item 24K.**



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)

1. 2. 3. 4.

| 24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

28. TOTAL CHARGE $ 29. AMOUNT PAID $ 30. BALANCE DUE $

***ELECTRONIC CLAIMS -*** The Performing Physician's PIN should be reported in the following fields.

**ANSI** - 2420A

REF01 = 1C

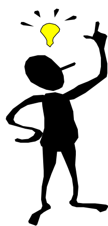
REF02 = PIN

If the PIN is missing or invalid, your claim will be denied or returned as unprocessable. When that happens, you will be required to file a brand new claim with the correct information.

***Note:*** *When implemented, the National Provider Identification (NPI) number will replace the PIN and UPIN. At that time, you will use the NPI number in items 17a, 24K, and 33.*

***Note:*** *With the implementation of the new CMS-1500 (08-05) version claim form the fields listed above may change. Please look for additional instructions regarding the new CMS-1500 (08-05) version claim form in future newsletters.*

The above instructions are included in Chapter 26 of the Medicare Claims Processing Manual. That manual isavailable at: http://www.cms.hhs.gov/manuals/downloads/clm104c26.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**<br>*www.arkmedicare.com* | **Louisiana**<br>*www.lamedicare.com* | **Missouri**<br>*www.momedicare.com* | **Oklahoma/New Mexico**<br>*www.oknmmedicare.com* | **Rhode Island**<br>*www.rimedicare.com* |
|---|---|---|---|---|
| Pinnacle Medicare Part B<br>Attn: Provider Education Specialist<br>P.O. Box 1418<br>Little Rock, AR<br>72203-1418 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 83760<br>Baton Rouge, LA<br>70884-3760 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 1418<br>Little Rock, AR<br>72203-1418 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 83760<br>Baton Rouge, LA<br>70884-3760 | Pinnacle Medicare Services<br>Attn: Provider Education Specialist<br>P.O. Box 1418<br>Little Rock, AR<br>72203-1418 |

---

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)*

**Seminars:**
Medicare seminars are designed to meet your needs. How can we improve our service to you?

_______ More frequent _______ Longer seminars _______ Specialty workshops

If you desire a specialty workshop, please indicate your specialty **and** topics to be addressed.

______________________________________________________________________________

______________________________________________________________________________

**Website:**
Have your ever visited our website? _______Yes _______No

If yes, how often do you visit our website?_____________________

Do you find the website easy to navigate? _______Yes _______No

Our websites are for your benefit. Please indicate suggestions/improvements below:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Thank you for your time and cooperation in responding to these questions. We value your input and constructive suggestions to help us better serve the medical community. Mail all completed forms to the carrier that services your state. Please do not forget to give us your name and telephone number.

____________________________________ (______)______________________________
Name Telephone Number

______________________________________________________________________
Street Address

______________________________________________________________________
City/State/Zip Code

## Audit guidelines for CPT codes 11040-11043 - Arkansas

*Reference: AR – DEC 060506*

A service specific and code specific rotating prepay audit will be implemented for Surgical Debridement codes 11040 - 11043. Data from previous probes preformed in May, June and August 2005, showed denial rates ranging from 37% - 73% for services billed. On follow-up review of data for the state Arkansas, there continues to be high utilization of these services in all specialties billing.

Medicare Services will also be looking at modifier 25 billed and E & M billed on the same date as the surgical debridement procedure. An OIG study has shown a high incidence of inappropriate billing of the Modifier -25 throughout the country. Their study showed that thirty-five percent of claims they reviewed using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. The link to this study is: http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

Based on this the decision was made to implement the above audit on a rotating basis. This audit will be set so that a random number of claims will be suspended per month per provider so as not to place any undue stress on any one provider or his/her office.

If an Additional Request Letter (ADR) is received, the providers must submit the appropriate medical record documentation to support the service being billed. Title XVIII of the Social Security Act, section 1862(a)(1) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Failure to submit the requested documentation will result in complete or partial denial of services.

Please submit the requested information within 30 days of receipt of the ADR letter:

(This is not an all inclusive list, if there are any other notes that would support the date of service please include in with the requested documentation.)

1. Care Plan with long and short term goals for the wound care. Please include initial evaluations of wound.
2. Documented follow-up by the patient's attending physician.
3. Documented evidence of the progress of the wound's response to treatment at each physician visit.
4. Debridement notes documenting the level of tissue removed; the method use to debride, and the character of the wound before and after debridement.
5. Please include the documentation supporting the E&M service billed with the Modifier -25 on the same date of service as the surgical procedure. This would include but not be limited to the office visit or subsequent hospital documentation for the date in question.

**Reference:**

- Medicare Part B Medical Policy Chronic Wound Care, Contractor Number AC-02-025 (Revised 2/4/05).
- Probe Review Results of Wound Care Services in Arkansas Provider News, October 2005, pg. 68-69
- Probe Review Results of Wound Care Services in Arkansas for CPT 11042 Provider News, December 2005, pg. 80-81
- Use of Modifier 25 (OEI-07-03-00470) http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

## Audit guidelines for CPT codes 11040-11043 - Louisiana

*Reference: AR – DEC 060506*

A service specific and code specific rotating prepay audit will be implemented for Surgical Debridement codes 11040 - 11043. Data from previous probes preformed in May, June, and August 2005, showed high denial rates ranging from 51% - 76% for services billed. On follow-up review of data for the state Louisiana, there continues to be high utilization of these services in all specialties billing.

Medicare Services will also be looking at modifier 25 billed and E & M billed on the same date as the surgical debridement procedure. An OIG study has shown a high incidence of inappropriate billing of the Modifier -25 throughout the country. Their study showed that thirty-five percent of claims they reviewed using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. The link to this study is: http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

Based on this information and the above data analysis, the decision was made to implement the above audit on a rotating basis. This audit will be set so that a random number of claims will be suspended per month per provider so as not to place any undue stress on any one provider or his/her office.

If an Additional Request Letter (ADR) is received, the providers must submit the appropriate medical record documentation to support the service being billed. Title XVIII of the Social Security Act, section 1862(a)(1) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Failure to submit the requested documentation will result in complete or partial denial of services.

Please submit the requested information within 30 days of receipt of the ADR letter:

(This is not an all inclusive list, if there are any other notes that would support the date of service please include in with the requested documentation.)

1. Care Plan with long and short term goals for the wound care. Please include initial evaluations of wound.
2. Documented follow-up by the patient's attending physician.
3. Documented evidence of the progress of the wound's response to treatment at each physician visit.
4. Debridement notes documenting the level of tissue removed; the method use to debride, and the character of the wound before and after debridement.
5. Please include the documentation supporting the E&M service billed with the Modifier -25 on the same date of service as the surgical procedure. This would include but not be limited to the office visit or subsequent hospital documentation for the date in question.

**Reference:**

- Medicare Part B Medical Policy Chronic Wound Care, Contractor Number AC-02-025 (Revised 2/4/05).
- Probe Review Results of Wound Care Services in Louisiana Provider News, October 2005, pg 71-72
- Probe Review Results of Wound Care Services in Louisiana for CPT 11042 Provider News, December 2005, pg 85-86
- Use of Modifier 25 (OEI-07-03-00470) http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

# Audit guidelines for CPT codes 11040-11043 - Missouri

*Reference: AR – DEC 060506*

A service specific and code specific rotating prepay audit will be implemented for Surgical Debridement codes 11040 - 11043. Data from previous probes preformed in June and July 2005, showed high denial rates ranging from 63% - 88% for services billed. On follow-up review of data for the state Missouri, there continues to be high utilization of these services in all specialties billing.

Medicare Services will also be looking at modifier 25 billed and E & M billed on the same date as the surgical debridement procedure. An OIG study has shown a high incidence of inappropriate billing of the Modifier -25 throughout the country. Their study showed that thirty-five percent of claims they reviewed using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. The link to this study is: http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf.

Based on this information and data analysis, the decision was made to implement the above audit on a rotating basis. This audit will be set so that a random number of claims will be suspended per month per provider so as not to place any undue stress on any one provider or his/her office.

If an Additional Request Letter (ADR) is received, the providers must submit the appropriate medical record documentation to support the service being billed. Title XVIII of the Social Security Act, section 1862(a)(1) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Failure to submit the requested documentation will result in complete or partial denial of services.

Please submit the requested information within 30 days of receipt of the ADR letter:

(This is not an all inclusive list, if there are any other notes that would support the date of service please include in with the requested documentation.)

1. Care Plan with long and short term goals for the wound care. Please include initial evaluations of wound.
2. Documented follow-up by the patient's attending physician.
3. Documented evidence of the progress of the wound's response to treatment at each physician visit.
4. Debridement notes documenting the level of tissue removed; the method use to debride, and the character of the wound before and after debridement.
5. Please include the documentation supporting the E&M service billed with the Modifier -25 on the same date of service as the surgical procedure. This would include but not be limited to the office visit or subsequent hospital documentation for the date in question.

**Reference:**


- Medicare Part B Medical Policy Chronic Wound Care, Contractor Number AC-02-025
- Probe Review Results of Wound Care Services in Missouri Provider News, October 2005, pg 77-78
- Probe Review Results of Wound Care Services in Missouri for CPT 11042 Provider News, December 2005, pg 91-92
- Probe Review Results of Wound Care Services in Missouri for CPT 11043 Provider News, December 2005, pg 93-94
- Use of Modifier 25 (OEI-07-03-00470) http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

## Audit guidelines for CPT codes 11040-11043 – Oklahoma/New Mexico

*Reference: AR – DEC 060506*

A service specific and code specific rotating prepay audit will be implemented for Surgical Debridement codes 11040 - 11043. Data from previous probes preformed in May, June and August 2005, showed high denial rates of 48% on all three probes in Oklahoma and denial rates ranging from 39% - 84% for services billed in New Mexico. On follow-up review of data for Oklahoma and New Mexico, there continues to be high utilization of these services in all specialties billing.

Medicare Services will also be looking at modifier 25 billed and E & M billed on the same date as the surgical debridement procedure. An OIG study has shown a high incidence of inappropriate billing of the Modifier -25 throughout the country. Their study showed that thirty-five percent of claims they reviewed using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. The link to this study is: http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

Based on this information and the above data analysis, the decision was made to implement the above audit on a rotating basis. This audit will be set so that a random number of claims will be suspended per month per provider so as not to place any undue stress on any one provider or his/her office.

If an Additional Request Letter (ADR) is received, the providers must submit the appropriate medical record documentation to support the service being billed. Title XVIII of the Social Security Act, section 1862(a)(1) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Failure to submit the requested documentation will result in complete or partial denial of services.

Please submit the requested information within 30 days of receipt of the ADR letter:

(This is not an all inclusive list, if there are any other notes that would support the date of service please include in with the requested documentation.)

1. Care Plan with long and short term goals for the wound care. Please include initial evaluations of wound.
2. Documented follow-up by the patient's attending physician.
3. Documented evidence of the progress of the wound's response to treatment at each physician visit.
4. Debridement notes documenting the level of tissue removed; the method use to debride, and the character of the wound before and after debridement.
5. Please include the documentation supporting the E&M service billed with the Modifier -25 on the same date of service as the surgical procedure. This would include but not be limited to the office visit or subsequent hospital documentation for the date in question.

**Reference:**

- Medicare Part B Medical Policy Chronic Wound Care, Contractor Number AC-02-025 Revised 2/4/05.
- Probe Review Results of Wound Care Services in New Mexico Provider News, October 2005, pg 82-83
- Probe Review Results of Wound Care Services in Oklahoma Provider News, October 2005, pg 84-85
- Probe Review Results of Wound Care Services in New Mexico for CPT 11042 Provider News, December 2005, pg 99-100
- Probe Review Results of Wound Care Services in Oklahoma for CPT 11042 Provider News, December 2005, pg 101-102
- Use of Modifier 25 (OEI-07-03-00470) http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

## 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.

## Audit guidelines for CPT codes 11040-11043 – Rhode Island

*Reference: AR – DEC 060506*

A service specific and code specific rotating prepay audit will be implemented for Surgical Debridement codes 11040 - 11043. Data from previous probes preformed in May, June and August 2005, showed high denial rates ranging from 80% - 93% for services billed. On follow-up review of data for the state Rhode Island, there continues to be high utilization of these services in all specialties billing.

Medicare Services will also be looking at modifier 25 billed and E & M billed on the same date as the surgical debridement procedure. An OIG study has shown a high incidence of inappropriate billing of the Modifier -25 throughout the country. Their study showed that thirty-five percent of claims they reviewed using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. The link to this study is: http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

Based on this information and the above data analysis, the decision was made to implement the above audit on a rotating basis. This audit will be set so that a random number of claims will be suspended per month per provider so as not to place any undue stress on any one provider or his/her office.

If an Additional Request Letter (ADR) is received, the providers must submit the appropriate medical record documentation to support the service being billed. Title XVIII of the Social Security Act, section 1862(a)(1) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Failure to submit the requested documentation will result in complete or partial denial of services.

Please submit the requested information within 30 days of receipt of the ADR letter:

(This is not an all inclusive list, if there are any other notes that would support the date of service please include in with the requested documentation.)

1. Care Plan with long and short term goals for the wound care. Please include initial evaluations of wound.
2. Documented follow-up by the patient's attending physician.
3. Documented evidence of the progress of the wound's response to treatment at each physician visit.
4. Debridement notes documenting the level of tissue removed; the method use to debride, and the character of the wound before and after debridement.
5. Please include the documentation supporting the E&M service billed with the Modifier -25 on the same date of service as the surgical procedure. This would include but not be limited to the office visit or subsequent hospital documentation for the date in question.

**Reference:**

- Medicare Part B Medical Policy Chronic Wound Care, Contractor Number AC-02-025 (Revised 2/4/05).
- Probe Review Results of Wound Care Services in Rhode Island – CPT 11040 Provider News, November 2005, pg 124-125
- Probe Review Results of Wound Care Services in Rhode Island – CPT 11040 Provider News, November 2005, pg 126-127
- Probe Review Results of Wound Care Services in Rhode Island for CPT 11042 Provider News, December 2005, pg 108-109
- Use of Modifier 25 (OEI-07-03-00470) http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

**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

*Any five-digit numeric Physician Current Procedural Terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 1999 American Medical Association. All Rights Reserved.*

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.

Pinnacle Medicare Services
12755 Olive Blvd.; Ste. 105
Creve Coeur, MO 63141
A CMS Contracted Carrier