



# Pinnacle Medicare Providers' News

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



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



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

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

The 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:

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

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

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

Name: \_\_\_\_\_

Attn: \_\_\_\_\_

Provider Number (if applicable): \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address (include zip): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Circle the state(s) for which you require a manual: AR LA MO NM/OK RI

If you have any questions, please call (314) 317-2732

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

**PINNACLE MEDICARE SERVICES**  
**Attn: Scott Thier**  
**12755 Olive Blvd., Suite 105**  
**Creve Coeur, MO 63141**



## *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:

- Ø Electronic Claims Filing
- Ø Electronic Remittance Advice
- Ø Medicare Remit Easy Print
- Ø HIPAA Compliant Transactions
- Ø 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:

- Ø IVANS: [www.ivans.com](http://www.ivans.com)  
1-800-548-2675
- Ø McKesson: [www.mckesson.com](http://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:

- Ø *Did you receive my claims?*
- Ø *Where are my claims in your system?*
- Ø *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:

|                             |  |
|-----------------------------|--|
| <b>Arkansas:</b>            | <a href="http://www.arkmedicare.com">www.arkmedicare.com</a>   |
| <b>Louisiana:</b>           | <a href="http://www.lamedicare.com">www.lamedicare.com</a>     |
| <b>Missouri:</b>            | <a href="http://www.momedicare.com">www.momedicare.com</a>     |
| <b>Oklahoma/New Mexico:</b> | <a href="http://www.oknmmedicare.com">www.oknmmedicare.com</a> |
| <b>Rhode Island:</b>        | <a href="http://www.rimedicare.com">www.rimedicare.com</a>     |

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

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

## **Deficit Reduction Act of 2005 – Nine Day Payment Hold**

*Reference: JSM CI 4060-06549, 07-12-06*

**This message is a reminder for all providers and physicians who bill Medicare contractors for their services.**

A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006.

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

Please note that payments will not be staggered and no advance payments will be allowed during this 9-day hold.

For more information, please view the MLN Matters Article at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf>

## *Ambulatory Surgical Center (ASC)*

### **Ambulatory Surgical Center (ASC) Claims Processing Manual Clarification**

*Reference: Trans. 975, CR #5026, Pub. 100-04, Medlearn Matters Number: MM5026*

**Note:** This article was revised on June 12, 2006, to reflect changes made to CR5026 on June 9, 2006. The article was revised to reflect a new CR release date, Transmittal number and Web address for CR5026. All other information remains the same.

***Provider Types Affected***

Providers and suppliers of ambulatory surgical center (ASC) services

***Provider Action Needed***

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

***Background***

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

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

Examples of such services include:

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

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

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

| Items or Services   | Who Receives Payment | Submit Bills To |
|---|----------------------|-----------------|
| <p><b>Physicians’ services</b><br/>Physicians who perform covered services in ASCs receive separate payment under Part B. Such services include:</p> <ul style="list-style-type: none"> <li>• Anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients’ recovery from the anesthesia;</li> <li>• Routine pre- or post- operative services, such as office visits, consultations, diagnostic tests,</li> </ul> | Physician            | Carrier         |

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

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

***Additional Information***

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

<http://www.cms.hhs.gov/Transmittals/downloads/R975CP.pdf>

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

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

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

## Care Plan Oversight (CPO)

### Non-Physician Practitioner (NPP) Payment for Care Plan Oversight (CPO)

Reference: Trans. 999, CR #4374, Pub. 100-04, Medlearn Matters Number: MM4374

**Note:** This article was revised on July 17, 2006, to reflect a correction made to related CR4374. CR4374 was corrected to show, in one statement, that HCPCS code G0182 refers to hospice oversight services, not home health services. This article was revised to replace “home health” to “hospice” in the 4th bullet point on page 3. The CR release date, transmittal number and web address were also changed, but all other information remains the same.

#### **Provider Types Affected**

Non-Physician Practitioners (NPPs) and suppliers billing Medicare carriers for home health CPO services

#### **Impact to You**

This article is based on Change Request (CR) 4374 which clarifies the policy associated with NPPs billing for physician home health care plan oversight (CPO).

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

The manual revision in CR4374 effectuates a revision to the policy that the same provider that signs the plan of care does not have to be the same provider that bills for physician care plan oversight. Effective January 1, 2005, NPPs must meet certain conditions to be eligible for payment for home health care plan oversight services even though they may not sign the plan of care. This CR clarifies those conditions.

CR4374 clarifies the policy associated with NPPs billing for physician hospice CPO and clarifies the HCPCS codes for CPO. It temporarily waives the requirement to include the Home Health Agency (HHA) or hospice provider number on a CPO claim since there is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number. CR4374 also states that the physician who bills CPO must be the same physician who signs the plan of care.

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

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

#### **Background**

Physician Care Plan Oversight (CPO) is paid under the Medicare Physician Fee Schedule (MPFS), and due to a provision in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 12, Section 180), Non-Physician Practitioners (NPPs) have been prohibited from billing for this service in a home health setting.

The current manual section (Section 180) provides that the physician who signs the plan of care for home health services must be the same person that bills for physician CPO. Since only a physician can sign the plan of care for home health services, NPPs have been unable to bill for physician home health CPO.

Under the Final Physician Fee Schedule Rule, published in the *Federal Register* on November 15, 2004, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), practicing within the scope of state law, may bill for CPO.

The intention of the Centers for Medicare & Medicaid Services (CMS), as outlined in later portions of the *Medicare Claims Processing Manual*, was to allow NPPs to bill for physician CPO within their state scope of practice. The current inconsistency in Section 180 will not allow NPPs to be paid for this service.

CR4374 revises the policy that states that the same provider that signs the plan of care does not have to be the same provider that bills for physician CPO.

In addition, the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 11, Section 40.1.3.1) has been revised to clarify CPO billing requirements for beneficiaries who have elected the hospice benefit.

Currently there is no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number required for a CPO claim. For this reason, the requirement to include the HHA or hospice

provider number on a CPO claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for CPO claims.

For services furnished on or after January 1, 2005, your carrier will allow NPPs to bill for physician home health CPO even though they cannot 1) certify a patient for home health services and 2) sign the plan of care.

For beneficiaries who have elected the hospice benefit, physicians or NPPs who have been identified by a beneficiary to be his or her attending physician may submit claims for CPO.

**Note:** For physicians or NPs who are employed by a hospice agency, CPO is not separately payable.

CR4374 instructs your carrier to:

- Pay for physician home health CPO services (HCPCS code G0181) when billed by an NPP for dates of service on or after January 1, 2005;
- Pay for physician home health plan CPO services (HCPCS code G0181) no more than once per calendar month per patient;
- Pay for physician hospice CPO services (HCPCS code G0182 with GV modifier) when billed by a nurse practitioner for dates of service on or after January 1, 2005;
- Pay for physician hospice CPO services under HCPCS code G0182 no more than once per calendar month per patient;
- Re-open and adjust any erroneously denied claims with practitioner CPO services brought to their attention; and
- Not require the provider numbers of the home health agency or hospice for CPO claims effective for dates of service on or after January 1, 2005.

### ***Implementation***

The implementation date for CR4374 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/R999CP.pdf>

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

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

## *Clinical Laboratory*

### **Healthcare Common Procedure Coding System (HCPCS) Correction for the Caffeine Halothane Contracture Test for Malignant Hyperthermia Susceptibility**

*Reference: Trans. 984, CR #5113, Pub. 100-04, Medlearn Matters Number: MM5113*

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

Providers billing Medicare carriers for laboratory tests

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

Effective January 1, 2006, you do not have to include a Clinical Laboratory Improvement Amendments (CLIA) number on claims that you submit for HCPCS code 89049 [Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report].

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

CR5113 provides that HCPCS code 89049 is not considered a test under CLIA. Therefore, performing this test does not necessitate that a facility has any CLIA certificate, nor require a CLIA number on claims for its use.

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

Make sure that your billing staffs are aware that they do not have to include a CLIA number on claims for HCPCS code 89049.

#### ***Background***

The CLIA regulations require a facility to be appropriately certified for each test that it performs. Therefore, laboratory claims are currently edited at the CLIA certificate level to ensure that Medicare and Medicaid only pay for laboratory tests that are performed in facilities with valid, current CLIA certificates.

This being said, CR5113, from which this article is taken, notifies carriers of one HCPCS correction for code 89049 [Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report]. While, currently, HCPCS code 89049 is subject to CLIA edits and has a laboratory certification (LC) code of 610 (histopathology), CR 5113 provides that this HCPCS code is not considered a test under CLIA.

Therefore, effective January 1, 2006, carriers will remove CLIA edits for HCPCS code 89049, including the LC code 610, and will not require a CLIA number on claims submitted by facilities for the HCPCS code 89049.

You should be aware that your carriers are not required to search their files to either retract payment or retroactively pay claims processed before this change is made. However, they will adjust claims brought to their attention.

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

You can find more information about billing for HCPCS code 89049 [Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report] by going to CR5113, located on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R984CP.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>

## Correction to CR4136: New Waived Tests

Reference: Trans. 988, CR #5131, Pub. 100-04, Medlearn Matters Number: MM5131

CR5131 corrects an incorrect Current Procedural Code (CPT) mentioned in the third sentence of the second paragraph in the background section of the Recurring Update Notification attachment for CR4136. Only this sentence has been revised. All other information remains as it is written in CR4136.

**Note:** This article was revised on July 11, 2006, to show that the effective date is January 1, 2006 and the implementation date is July 24, 2006. These dates were inadvertently transposed on the original article.

### *Provider Types Affected*

All providers and suppliers billing Medicare carriers for laboratory tests

### *Background*

CR5131 corrects an incorrect Current Procedural Code (CPT) mentioned in the third sentence of the second paragraph in the background section of the Recurring Update Notification attachment for CR4136.

### *Key Points*

This article and CR5131 identifies the correction issued by the Centers for Medicare & Medicaid Services (CMS) regarding the “Waived Tests:”

- CPT code **82271** was **incorrectly listed** in the second paragraph of the background section of the Recurring Update Notification attachment of CR4136 as not requiring a QW modifier. The CPT code should have been **82272** and it does not require a QW modifier.
- All other information that outlines which tests require the “QW modifier” and which do not require the “QW modifier” remains the same as listed in CR4136. (The web address for MLN Matters article MM4136 related to CR4136 is <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4136.pdf> on the CMS web site.)

### *Implementation*

The effective date for this instruction was January 1, 2006, and the correction by CR5131 will be implemented on July 24, 2006.

### *Additional Information*

The official instruction, CR5131, issued to your Medicare carrier regarding this change can be found on the CMS web site at:

<http://www.cms.hhs.gov/transmittals/downloads/R988CP.pdf>

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>

## Coding & Coverage

### New Current Procedural Terminology (CPT) Code

Reference: Trans. 910, CR #4222, Pub. 100-04, Medlearn Matters Number: MM4222

#### Provider Types Affected

All Medicare providers

#### Impact to You

Effective July 1, 2005, Medicare carriers and intermediaries must use the new Current Procedural Terminology (CPT) code 90714 (*Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use*) for services previously billed under CPT code 90718.

#### What You Need to Know

Effective for services on or after July 1, 2005, if you do not use the new Current Procedural Terminology (CPT) code, 90714, reimbursements may be impacted. CR4222 provides notification of this new CPT code for tetanus and diphtheria toxoids (see table below).

#### What You Need to Do

Make sure that your billing staffs are aware of this new CPT code.

#### Background

Effective July 1, 2005, the following vaccine CPT code is being added to the CPT system.

| CPT Code | Short Descriptor            | Long Descriptor  |
|----------|-----------------------------|--|
| 90714    | Td vaccine no prsrv >= 7 im | Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individual seven years or older, for intramuscular use |

**Note:** Your carriers and fiscal intermediaries will assign the CPT code (90714) to status indicator “E” in the Medicare Physician Fee Schedule Database. Deductible and coinsurance apply.

Effective July 1, 2005:

- CPT code 90718 is used for the tetanus and diphtheria toxoids (Td) vaccine absorbed for use in an individual seven years or older, for intramuscular use; and
- CPT 90714 is used for the tetanus and diphtheria toxoids (Tg) vaccine absorbed, preservative free, for use in individuals seven years or older, for intramuscular use.

#### Additional Information

Medicare will not search its files to retract payment for claims already paid or to retroactively pay claims. However, carriers/intermediaries will adjust claims brought to their attention.

The official instruction issued to your carrier/intermediary is available on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R910CP.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 Islet Cell Transplantation in NIH-Sponsored Clinical Trials

Reference: *Trans. 986, CR #5140, Pub. 100-04, Medlearn Matters Number: MM5140*

## **Provider Types Affected**

Physicians, suppliers, and providers billing Medicare contractors (carriers and fiscal intermediaries (FIs))

## **Impact to You**

The Centers for Medicare & Medicaid Services (CMS) is updating the modifier used for claims for islet cell transplantation and for routine follow-up care related to the transplantation in NIH-sponsored clinical trials.

## **What You Need to Know**

Please note that effective for islet cell transplantation and routine follow-up services related to the islet cell transplantation on or after **May 1, 2006, the QV modifier is no longer valid. The QR modifier** (item or service provided in a Medicare-specified study) **will replace the QV modifier for services on or after May 1, 2006.**

## **What You Need to Do**

Refer to the *Background and Additional Information* sections of this article for more information. Be ready to use the new QR modifier for payment of islet cell transplantation and routine follow-up care when appropriate.

## **Background**

As a result of section 733 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173), for services performed/discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with Type I diabetes who are participating in an NIH-sponsored clinical trial. The islet cell transplantation may be done alone or in combination with kidney transplantation.

## **Additional Information**

Effective for services on or after **May 1, 2006**, Medicare will **accept the QR modifier** for payment on claims for patients who participate in an NIH-sponsored clinical trial in conjunction with:

- Islet cell transplantation; and
- Routine follow-up care related to islet cell transplantation, when:
  - Ø Performed in an outpatient department of a hospital; and
  - Ø Billed on type of bill (TOB) 13X or 85X.

For additional information, please refer to MM3385, "MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial," which can be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3385.pdf>

Also, refer to the *Medicare National Coverage Determinations Manual*, publication 100-03, Chapter 1, Part 4, Section 260.3.1 "Islet Cell Transplantation in the Context of a Clinical Trial (Effective October 1, 2004)," located on the CMS web site at:

[http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part4.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf)

CR5140 is the official instruction issued to your Medicare carrier or FI regarding changes mentioned in this article, and the manual attachment to CR5140, the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 32, "Billing Requirements for Special Services," Section 70 "Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial." CR5140 may be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R986CP.pdf>

If you have questions, please contact your Medicare 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>

# Claim Status Category Code and Claim Status Code Update

Reference: Trans. 987, CR #5137, Pub. 100-04, Medlearn Matters Number: MM5137

## ***Provider Types Affected***

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

## ***Impact to You***

This article is based on Change Request (CR) 5137, which provides the October 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

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

Medicare contractors are to use codes with the “**new as of 10/06**” designation and prior dates, and they must inform affected providers of the new codes. CR5137 applies to Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

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

Please refer to the Background section of this article for further details.

## ***Background***

Claim Status Category codes indicate the general category of a claim’s status (accepted, rejected, additional information requested, and so on). Further detail is provided by the Claim Status Code(s).

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the Claim Status Category and Claim Status codes. The Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

The updated Claim Status Category and Claim Status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company web site at <http://www.wpc-edi.com/codes>. At this web site, select “Claim Status Codes” or “Claim Status Category Codes” to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

## ***Implementation***

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

## ***Additional Information***

For complete details, please see CR5137, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI regarding changes mentioned in this article. CR5137 may be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R987CP.pdf>

If you have questions please contact your Medicare carrier/DMERC or FI/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>

# Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information

Reference: Trans. 991, CR #5138, Pub. 100-04, Medlearn Matters Number: MM5138

## **Provider Types Affected**

Physicians, providers, suppliers, and clearinghouses who bill Medicare fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs), and who use the HIPAA 270/271 beneficiary eligibility transaction data in a real-time environment via the Centers for Medicare & Medicaid Services (CMS) AT&T communication Extranet

## **Background**

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well.

## **Key Points**

Change Request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary's Medicare eligibility data. The following key points outline those responsibilities:

### **EDI Enrollment**

The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse.

Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.

Physicians/providers/suppliers should remember that they agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of information are authorized and all beneficiary-specific data is protected from improper access. Acting on behalf of the beneficiary, physicians/providers/suppliers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information.

### **Authenticating Data Elements for HIPAA 270/271 Eligibility Data**

Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:

- Beneficiary last name (must match the name on the Medicare card);
- Beneficiary first name or first initial (must match the information on the Medicare card);
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN) including both alpha and numerical characters; and
- Date of birth.

### **Medicare Beneficiary as First Source of Health Insurance Eligibility Information**

The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. It is important to use the name as shown on the Medicare card.

If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

### **Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information**

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare;
- Determine beneficiary payment responsibility with regard to deductible/coinsurance;
- Determine eligibility for services such as preventive services;
- Determine if Medicare is the primary or secondary payer;
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage); and
- Determine proper billing.

Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of "individually identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

**Note:** Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

### **Criminal Penalties' Provisions**

Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

#### **1. Trading Partner Agreement Violation**

42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person."

Offenders shall "(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both."

#### **2. False Claim Act**

Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

### 3. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HHS may impose civil money penalties on a covered entity of \$100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of \$50,000 and up to one-year imprisonment. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

#### *Implementation*

The implementation date for this instruction is July 24, 2006.

#### *Additional Information*

CR5138, the official instructions issued to your Medicare FI, carrier, RHHI, and DMERC regarding this change, can be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R991CP.pdf>

The revised section Chapter 31—ANSI X12N Formats Other than Claims or Remittance of the Medicare Claims Processing Manual is attached to CR5138. If you have questions, please contact your Medicare FI, carrier, RHHI, or DMERC at their toll-free number, which may be found on the CMS web site at:

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

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## Notice of New Interest Rate for Medicare Overpayments and Underpayments

*Reference: Trans. 102, CR #4076, Pub. 100-06*

Effective **July 19, 2006**, the interest rate for overpayments and underpayments will change to **12.625 percent**. Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (two percent for calendar year 2006) or the private consumer rate (PCR). The Department of the Treasury has notified the Department of Health and Human Services that the PCR rate will change to **12.625 percent**.

# Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Reference: Trans. 990, CR #5142, Pub. 100-04, Medlearn Matters Number: MM5142

## **Provider Types Affected**

Physicians, suppliers, and providers billing Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

## **Impact to You**

Medicare has issued the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers.

## **What You Need to Know**

An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers (ASCs), and for all institutional claims, but is **not required for ambulance supplier claims**.

## **What You Need to Do**

Be ready to use the updated codes on October 1, 2006. Please refer to the *Background and Additional Information* sections of this article for further details regarding this instruction.

## **Background**

This instruction is a reminder that Medicare carriers, DMERCs, FIs, and RHHIs will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2006; and
- Discharges on or after October 1, 2006 for institutional providers

Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR3094, dated February 6, 2004 on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3094.pdf>

## **Implementation**

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

## **Additional Information**

### **Publication of ICD-9-CM Codes**

- The Centers for Medicare & Medicaid Services (CMS) places the new, revised, and discontinued codes at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage) on the CMS web site: The update should be available at this site in June.
- The updated codes can also be viewed at the National Center for Health Statistics (NCHS) web site at: <http://www.cdc.gov/nchs/icd9.htm>. This posting should be available at this site in June.
- Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) Chapter 23 may be accessed on the CMS web site at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

To view CR5142, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI, regarding changes mentioned in this article. CR5142 may be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R990CP.pdf>

If you have questions, please contact your Medicare carrier/DMERC or FI/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>

# Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds

Reference: Trans. 977 and 59, CR #5123, Pub. 100-04 and 100-03, Medlearn Matters Number: MM5123

## ***Provider Types Affected***

Physicians, providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for chronic non-healing wound related services furnished to Medicare beneficiaries.

## ***Impact on Providers***

This article is based on Change Request (CR) 5123 which instructs Medicare contractors (carriers, FIs, and RHHIs) that claims submitted for **becaplermin**, a self-administered, non-autologous growth factor for chronic, non-healing, subcutaneous wounds **will remain non-covered**.

Becaplermin, Healthcare Common Procedure Coding System (HCPCS) **S0157**, is nationally non-covered because it is usually self-administered by the patient.

## ***Background***

After releasing a national non-coverage determination (NCD) on Autologous Blood-Derived Products for Chronic Non-Healing Wounds in December of 2003, an error was printed in the NCD Manual.

To correct that error, the Centers for Medicare & Medicaid Services (CMS) is revising section 270.3 of the *National Coverage Determinations (NCD) Manual* (Publication 100-03, Chapter 1, Part 3, "Blood-Derived Products for Chronic Non-Healing Wounds") to accurately reflect the payment policy for non-autologous blood derived products for chronic non-healing wounds, effective April 27, 2006.

In this revision, the following sentence is being deleted:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous non-healing wounds, will remain at local carrier discretion. Becaplermin is approved by the Food and Drug Administration."

The correct statement should read:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, **will remain nationally non-covered** under Part B based on §1861(s)(2)(A) and §1861(s)(2)(B) because this product is usually self-administered by the patient."

While CMS makes every effort to provide accurate and complete information, the erroneous coverage statement printed in the NCD Manual regarding non-autologous blood-derived products was not intended, and is not part of the Decision Memorandum (DM) posted on December 15, 2003. Non-autologous blood-derived products are not in the same class as the products referred to in the December 15, 2003, DM.

NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1060)(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD (see section 1869(f)(1)(A)(i) of the Social Security Act).

## ***Additional Information***

CR5123 is the official instruction issued to your Medicare carrier or FI/RHHI regarding changes mentioned in this article. There are two transmittals for CR5123. Transmittal 59, containing the NCD revision, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R59NCD.pdf> on the CMS web site. Transmittal 977, containing the Medicare claims processing instructions, is at <http://www.cms.hhs.gov/Transmittals/downloads/R977CP.pdf> on the CMS web site.

If you have questions please contact your Medicare carrier/FI/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>

## Lumbar Artificial Disc Replacement (LADR)

Reference: Trans. 60 and 992, CR #5057, Pub. 100-03 and 100-04, Medlearn Matters Number: MM5057

### *Provider Types Affected*

All physicians and providers who bill Medicare carriers and fiscal intermediaries (FIs) for LADR

### *Providers Action Needed*

This article and Change Request (CR) 5057 provide specific information regarding the new national coverage determination (NCD) for LADR. The message is three-pronged:

1. Effective May 16, 2006, the LADR with the Charite lumbar artificial disc is not covered by Medicare for beneficiaries over 60 years of age, i.e., on or after the beneficiary's 61st birthday;
2. Medicare coverage under the investigational device exemption (IDE) and/or clinical trial policy for other lumbar artificial discs is not impacted by this decision and such coverage continues if the billing requirements are met and the appropriate codes are submitted; and
3. For patients 60 years of age and younger, there is no NCD, leaving such determinations to continue to be made by the local contractors.

### *Background*

The Centers for Medicare & Medicaid Services (CMS), upon completion of a national coverage analysis (NCA) for LADR, determined that LADR with the Charite lumbar artificial disc is not reasonable and necessary for Medicare patients over 60 years of age and is, therefore, non-covered for this patient population. For Medicare beneficiaries 60 years of age and younger, there is no NCD, leaving such determinations to be made by the local Medicare carrier or FI.

This NCD focuses on the LADR with the Charite lumbar artificial disc because it is the only United States Food and Drug Administration (FDA) approved lumbar artificial disc at this time. The FDA has approved the use of the Charite artificial disc for spine arthroplasty in skeletally mature patients with degenerative or discogenic disc disease (DDD) at one level for L4 to S1.

The addition of section 150.10 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

### *Billing Requirements*

The following are the billing requirements for LADR according to the revised *Medicare Claims Processing Manual*, Chapter 32, Section 170, which is effective May 16, 2006.

- Assuming the providers bill separately, physicians and hospitals need to **issue the appropriate liability notice**, (Advance Beneficiary Notice (ABN) or Hospital Issued Notice of Non-coverage (HINN), to beneficiaries over 60 years of age who choose to have this procedure using the Charite lumbar artificial disc.
- The following language should be included in the ABN:
  - Ø Under the "Items or Service" Section: Lumbar Artificial Disc Replacement (LADR) with the Charite Lumbar Artificial Disc.
  - Ø Under the "Because" Section: After a national coverage analysis (NCA), Medicare issued a national coverage determination (NCD) (Section 150.10 of *Medicare NCD Manual*) that stated that LADR with the Charite Lumbar Artificial Disc is not reasonable and necessary for Medicare beneficiaries over 60 years of age. Therefore, LADR with the Charite lumbar artificial disc is non-covered for beneficiaries over 60 years of age. Medicare never pays for this service for this Medicare population.
- Hospitals need to have a **beneficiary who is over 60 years of age sign a HINN** if he/she wishes to have the procedure done when a Charite lumbar artificial disc is used in the procedure. If the beneficiary is not informed prior to admission that he or she is financially liable for the admission, the provider is liable.

### **Information for Providers Billing Carriers**

- For patients over 60 years of age claims submitted with Category III Codes 0091T (Single interspace, lumbar) and/or 0092T (Each additional interspace) will be denied unless performed under an approved IDE/clinical trial. (**Note:** The Charite lumbar artificial disc is the only artificial disc approved by the Food and Drug Administration, therefore the procedure (0091T or 0092T) would be using the Charite unless under an IDE/clinical trial.)
- For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, claims submitted with 0091T or 0092T and the modifier QA will be allowed and normal claims processing criteria for IDEs/clinical trials will be followed.

### **Information for Providers Billing FIs**

For patients over 60 years of age, claims submitted with ICD-9 CM procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is never payable and will be denied unless performed under an approved IDE/clinical trial.

For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, the FI will pay for LADR only when submitted with ICD-9 procedure code 84.65 with condition code 30 and diagnosis code V70.7 when submitted on type of bill (TOB) 11X.

- For services submitted on TOB 11X in critical access hospitals (CAH), the payment will be 101% of reasonable cost.
- For services submitted on TOB 11X from inpatient hospitals, including Indian Health Services (IHS) inpatient hospitals will be paid under IPPS based on the DRG.
- For services submitted/performed on TOB 11X, IHS CAHs will be paid under 101% facility specific per diem rate.

### **Medicare Summary Notice (MSN) and Claim Adjustment Reason Code Messages for Denied Claims**

- The following MSN: 21.24 will be issued: "This service is not covered for patients over age 60." along with a Claim Adjustment Reason Code such as: 96 "Non-covered charge(s)."

### **Implementation**

The implementation date for this instruction is July 17, 2006, for claims submitted to carriers and October 1, 2006, for claims submitted to Medicare FIs. But, in both instances, the change applies to services provided on or after May 16, 2006.

### **Additional Information**

The official instructions issued to your Medicare carrier and intermediary regarding this change are in two transmittals for CR5057. Transmittal R60NCD contains the NCD instructions and can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R60NCD.pdf> on the CMS web site. The claims processing instructions are in Transmittal R992CP, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R992CP.pdf>.

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

# Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes

Reference: Trans. 995, CR #5118, Pub. 100-04, Medlearn Matters Number: MM5118

## Provider Types Affected

Physicians, providers, and suppliers who provide services to Medicare beneficiaries enrolled under Medicare Part C

## Impact on Providers

CR5118 provides notice that effective January 2006, Medicare Part C plan contract numbers can begin with a character other than an "H."

As a result of changes in the assignment of Medicare Part C plan contract numbers, the entire five-position alpha/numeric Medicare Part C plan contract number will be provided to the common working file (CWF), which is a key file used by Medicare systems to provide beneficiary information to providers.

Currently, the CWF places an "H" in front of the Part C plan number, since prior to January 1, 2006, all plan numbers began with an "H." Once this change is implemented, the correct and complete plan contract numbers will then be on the CWF and will be given to providers when they inquire about Medicare beneficiaries.

## Background

CWF contains data indicating when a beneficiary is enrolled under a Medicare Part C contract. Medicare Part C contracts are Medicare Advantage Managed Care Plans that provide Part A and B benefits for beneficiaries enrolled under the contract. CWF receives this Part C data on a data feed from the Enrollment Database (EDB), another Medicare database. Effective January 1, 2006, Part C contract numbers can begin with a letter other than "H" and the Medicare CWF is being modified to handle this change, so correct numbers are sent to providers as part of beneficiary information.

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](http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage)

The number that will appear on CWF will begin with "H." For the following 11 plans, the alpha prefix is actually an "R." Prior to October, when using the web page look-up tool, make sure to replace the "H" with an "R." The 11 plans are the following:

|       |       |       |
|-------|-------|-------|
| R3175 | R5566 | R5863 |
| R5287 | R5595 | R5941 |
| R5342 | R5674 | R9943 |
| R5553 | R5826 |       |

## Implementation

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

## Additional Information

CR5118 is the official instruction issued to your Medicare carrier/durable medical equipment regional carrier (DMERC) or fiscal intermediary (FI) regarding changes mentioned in this article. CR5118 may be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R995CP.pdf>

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

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

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

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

**Note:** This article was revised on July 6, 2006, to reflect revisions made to CR5105, which CMS released on July 3, 2006. The Transmittal number, CR release date, and web address for accessing CR5105 have been changed. In addition, some references to MA (Medicare Advantage) have been changed to refer to managed care plans. All other information remains the same.

## ***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 Managed Care 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 managed care 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 managed care 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 managed care 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 managed care 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](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/R100FM.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>

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## **CMS Electronic Mailing Lists - Reminder**

*Reference: JSM CI 4019-06504, 06-22-06*

The Centers for Medicare & Medicaid Services (CMS) offers a way for you to receive consistent and accurate information regarding recent news, policy changes and updates: **CMS Mailing Lists**.

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

The CMS Mailing Lists Fact Sheet can be copied and distributed as handouts at your association conferences, etc. Hardcopies can also be ordered by going to the MLN Products Ordering Page at:

[http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5)

## ***Comprehensive Error Rate Testing (CERT)***

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

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

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

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

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

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

## Drug Pricing

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

Reference: Trans. 974, CR #5110, Pub. 100-04, Medlearn Matters Number: MM5110

**Note:** This article was revised on July 17, 2006, to include an additional web address in the “Additional Information” section. This address houses Part B Drug information and the quarterly ASP Medicare Drug Pricing Files.

#### *Provider Types Affected*

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers including durable medical equipment regional carriers (DMERCs)) for services.

#### *Impact to You*

CR5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files.

#### *What You Need to Know*

Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR5110.

#### *What You Need to Do*

Make certain that your billing staffs are aware of this change.

#### *Background*

According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM4319.pdf>), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

Pricing for compounded drugs is performed by the local Medicare contractor.

#### **ESRD Drugs**

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

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

#### **Exceptions**

There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM4319.pdf> on the CMS website.

With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded.

The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs)

are 95 percent of the first published AWP, unless the drug is compounded.

### **Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir**

Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient's illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication effectively.

### **How the ASP Is Calculated**

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

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

The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

### **Implementation**

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

### **Additional Information**

The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located on the CMS web site at: <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf>

Quarterly Part B Drug Pricing files and information are also available on the CMS web site at: <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice>

CR5110 is the official instruction issued to your Medicare carrier/FI/RHHI/DMERC regarding changes mentioned in this article. CR5110 may be found on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R974CP.pdf>

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

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

## DMEPOS

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

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

**Note:** This article was revised on June 2, 2006, to show that codes K0734-K0737 are added to the fee schedule file and are effective for claims submitted with dates of service on or after July 1, 2006, not January 1, 2006.

#### *Provider Types Affected*

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

#### *Providers Action Needed*

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

#### *Background*

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

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

Payment on a fee schedule basis is required for:

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

#### *Changes Made in the Update*

Changes made in this update include the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### ***Implementation***

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

### ***Additional Information***

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

<http://www.cms.hhs.gov/Transmittals/downloads/R928CP.pdf>

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

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

## General

### Additional Documentation Request (ADR) or CERT Letter - What Do I Need to Send In?

Reference: MO – LSB 070606

One of the largest claim denial reasons, both nation-wide and within the Pinnacle Business Solutions, Inc. Medicare Coverage Area, is **insufficient documentation**. This article is designed to explain the documentation requirements for many of the areas which are deficient. The specific type of service will be noted (alphabetical order), followed by a list of the required documentation from the medical record that must be sent when an ADR letter or CERT letter is received by the provider.

All documentation would be expected to support the CPT<sup>®</sup> and ICD-9 codes billed according to Local and National Coverage Determinations or CMS Manuals references, whichever is applicable. Please note: For all records, if the medical records are illegible or difficult to read, the provider/supplier should include a typewritten interpretation of the actual documentation and send both the original and the typewritten interpretation (noted by the provider to be correct). Also, if the provider/supplier does not have the required information to support medical necessity for the service, he/she is expected to obtain the records from the appropriate source and submit the information as requested. **These are not all-inclusive lists**. If there are any other notes that would support the date of service, they should be included with the requested documentation.

#### **Ambulance Services (Ground) (Publication 100-04, Chapter 15)**

1. Ambulance run reports with date, origin, destination, and number of miles traveled
2. Equipment/supplies used in patient's transport
3. List of medications used during patient's transport
4. Treating physician
5. Medical condition of the patient necessitating the need for ambulance transport

#### **Carotid Doppler (LCD AC-02-055)**

1. Progress/clinical notes for the date(s) of service requested detailing the relevant symptoms/complaints/condition(s)
2. Physician orders, if appropriate
3. Date test completed
4. Signed report of carotid Doppler findings/results
5. Documentation to support medical necessity as outlined in LCD

#### **Chest X-rays (LCD AC-01-005)**

1. Physician's order for the procedure
2. Physician progress note documenting the necessity for the procedure
3. Date of test
4. X-ray results/interpretation with signature

#### **Chiropractic Services (LCD AC-01-006)**

1. Initial history detailing the patient's specific complaint(s)
2. Exam
  - a. Detailing specific abnormal physical findings
  - b. Detailing level of subluxation
3. The plan of care
  - a. Including frequency and duration
4. The daily notes
  - a. For each specific DOS requested
  - b. Indicating the regions to which the manipulation was performed,

- c. Any other pertinent documentation to support that the service(s) billed was reasonable and necessary

**Critical Care Services (LCD AC-01-007)**

1. All progress notes made by physician or by physician in the group practice
  - a. Supports cumulative critical care during the 24 hour period of the date of service billed
2. Progress notes from the day immediately preceding the date of service billed
3. Progress notes from the day following the date of service billed
4. Physician orders
5. Name of beneficiary and date of service documented on all notes
6. Documentation of cumulative time spent for critical care delivery
7. Documentation includes criteria for critical care to determine medical necessity of service
8. Legible signature of billing provider
9. Any other pertinent documentation to support that the service(s) billed was
  - a. Reasonable
  - b. Necessary
  - c. Correctly coded

**Evaluation and Management Services (Emergency Department [ED]) (1995 and 1997 Documentation Guidelines)**

1. All ED records for the date of service requested.
  - a. Name of beneficiary and date of service documented on all notes
2. Physician orders
3. Test results, if appropriate
4. Legible signature of the billing provider

**Evaluation and Management Services (Initial Hospital) (1995 and 1997 Documentation Guidelines)**

1. All progress/clinical notes for the date of service requested
  - a. Name of beneficiary and date of service documented on all notes
  - b. Reference to and submission of resident's note, if applicable
2. Physician orders, if appropriate
3. Test results, if appropriate
4. Legible signature of the billing provider

**Evaluation and Management Services (Office or Other Outpatient Facilities) 1995 and 1997 Documentation Guidelines)**

1. Progress/clinical notes for the date(s) of service requested
  - a. Name of beneficiary and date(s) of service documented on all notes
2. Physician orders, if appropriate
3. If documenting based on counseling or coordination of care include
  - a. Total time
  - b. Amount or percent of time involved in counseling or coordination of care
  - c. Description of the discussion/care involved.
4. When billed on the same date as a procedure, documentation that the service reflects evaluation and management of a separate condition, unrelated to the procedure performed.
5. Legible signature of the billing provider

**Evaluation and Management Services (Skilled Nursing Facility) (1995 and 1997 Documentation Guidelines)**

1. Progress/clinical notes for the date(s) of service requested
  - a. Name of beneficiary and date(s) of service documented on all notes

2. Physician orders, if appropriate
3. Legible signature of the billing provider
4. Any other notes that would support the medical necessity for the date of service

**Evaluation and Management Services (Subsequent Hospital) (1995 and 1997 Documentation Guidelines)**

1. The physician progress notes documenting
  - a. Interval history, physical exam, and medical decision making for the date(s) of service requested
  - b. Reference to and submission of resident's note, if applicable
  - c. Name of beneficiary and date(s) of service documented on all notes
2. Other supporting documentation required for the level of service billed
  - a. Physician orders
  - b. Test results
3. If documenting based on counseling or coordination of care include
  - a. Total time
  - b. Amount or percent of time involved in counseling or coordination of care
  - c. Description of the discussion/care involved.
4. Legible signature of the billing provider

**Hyperbaric Oxygen Therapy (HBO) (LCD AC-01-012 and NCD 02-29)**

1. Approved diagnosis(es) as indicated in the policies
2. Copy of the initial assessment to include:
  - a. History of condition requiring HBO
  - b. Prior treatments and their results
  - c. Antibiotic therapies
  - d. Surgical interventions
  - e. Any adjunctive treatment currently being rendered
3. Documentation showing there has been no measurable signs of healing after at least 30 consecutive days of standard wound care prior to the start of HBO therapy
4. MD Progress notes to reflect the following:
  - a. Physical findings at each treatment
  - b. Effect of treatment including wound description
5. HBO Treatment Report/Record indicating the following:
  - a. Dates and times of HBO treatment
  - b. Physical findings
6. Any communication between physicians
7. Proposed plan of care to include frequency and duration of treatments
8. Indications of effective treatment outcomes for HBO as follows:
  - a. There is improvement or healing of wounds
  - b. There is improvement of tissue perfusion
  - c. There is new epithelial tissue growth and granulation
  - d. Tissue PO<sub>2</sub> of at least 35mmHg of oxygen is necessary for oxidative function
  - e. The mechanism reduction in the bubble size of air emboli alleviates decompression sickness and gas/air emboli
  - f. Tissue PO<sub>2</sub> of 45mmHg or greater defines resolved hypoxia. The body can now resume wound healing and anti-microbial defenses without the need of HBO

**Infliximab (Remicade) Injection (LCD AC-99-524)**

1. Medical records detailing
  - a. The condition requiring treatment with infliximab, and
  - b. Signs and symptoms for which infliximab is being prescribed
2. Documentation of response to other therapies
  - a. Duration, dosage, and response to methotrexate administration (if applicable)
3. Evidence of unequivocal diagnosis of RA (if applicable)
  - a. Improvement (as judged by ACR 20 criteria) should be noticeable at the 30 week follow-up
  - b. If no improvement occurs, then Medicare will not cover continued treatment
  - c. For treatment beyond 30 weeks, there must be documentation of demonstrable improvement.
4. Presence and locations of fistulas (if applicable)
5. Dosage and treatment frequency
6. Response to treatment
7. Injection record
8. Any other pertinent documentation to support that the service(s) billed was
  - a. Reasonable
  - b. Necessary
  - c. Correctly coded

**Laboratory/Pathology Services (Applicable LCDs or NCDs for Individual Tests)**

1. Physician referral
2. Documentation of limited diagnosis from the policy if covered by NCD or LCD
3. Evidence that the test was performed, including date
4. Laboratory test results
5. Signed pathology report
6. ABN, if applicable
7. Evidence of separate specimens, if applicable
8. Orders for any follow-up tests required due to diagnosis

**Ophthalmoscopy (Extended) (LCD AC-02-058)**

1. Office notes for the date(s) of service billed
2. Documentation of the presence of a serious retinal condition which, based on ophthalmoscopy, requires further study
3. Another diagnostic technique in addition to routine direct and indirect ophthalmoscopy is necessary and documented
4. Findings of the extended ophthalmoscopy must be documented
  - a. Includes a three-dimensional representation or an extended colored retinal drawing

**Physical Therapy/Occupational Therapy/ Speech Language Pathology Services (LCD AC-02-059)**

1. Physician's order for therapy
2. Therapy initial evaluation/re-evaluation
3. Plan of care or treatment plan
4. Physician/NPP Certification/Re-certification
5. Treatment encounter notes for every treatment day and every therapy service including the following:
  - a. Date of treatment
  - b. The name of the treatment, intervention, or activity provided
  - c. Type of equipment used

- d. Time spent in services represented by timed codes
  - e. Total treatment time (including the untimed service codes)
  - f. Signature and professional identity of qualified professional who furnished or supervised and list of each person contributing to treatment during that encounter
  - g. Record and justification of any changes:
    - If treatment is added
    - If treatment is changed
    - Between the interval progress reports
6. Progress Reports
  7. Interpretation of abbreviations used in therapy notes
  8. Initial date of service

**Podiatry Services for Nail Debridement (LCD AC-03-003)**

1. The signed, clinical notes for the date of service requested
2. Signed procedure report(s) for the date of service requested
3. Name of beneficiary and date of service on each of the notes
4. Referring physician, if applicable
5. Date last seen by attending physician, if applicable
6. Any other pertinent documentation to support that the service(s) billed was:
  - a. Reasonable
  - b. Necessary
  - c. Correctly coded

**Psychiatry/Psychology Services (LCD AC-05-002)**

1. Progress/clinical notes for the date(s) of service requested
2. Target symptoms, therapeutic goals, and patient's ability to participate in and benefit from treatment
  - a. For acute problems, documentation treatment expected to improve health status or function of the patient
  - b. For chronic problems, documentation stabilization or maintenance of health status or function is expected
3. Established duration, in terms of sessions and time spent in therapy, if appropriate
4. Therapeutic testing and methods and reason for choice of specific treatment modality
5. Method of monitoring outcomes
6. Pharmacological Management, if appropriate
7. Physician orders, if appropriate

**Surgical Debridement in Wound Care (LCD AC-02-025)**

1. Care Plan with
  - a. Initial evaluation of the wound
  - b. Long and short term goals for the wound care
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
  - a. The level of tissue removed
  - b. The method used to debride the wound
  - c. The character of the wound before and after debridement, including standardized assessment tools, if applicable

## **References:**

1. *Current Procedural Terminology 2006* Copyright© 2005 American Medical Association. All Rights Reserved. CPT® is a trademark of the American Medical Association.
  2. *Health Care Procedure Coding System 2006* Copyright© 2005 by Practice Management Information Corporation, Los Angeles, California 90010. All rights reserved.
  3. *International Classification of Diseases 9th Revision 2006* Copyright© 2005 by Practice Management Information Corporation, Los Angeles, California 90010. All rights reserved.
  4. Local Coverage Determinations (LCDs) may be found on your local website under Providers, then Publications, then Manuals, Final Local Coverage Determinations (either Part A or Part B).
  5. National Coverage Determinations (NCDs) may be found at the following website:  
[http://www.cms.hhs.gov/mcd/index\\_list.asp?list\\_type=ncd](http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd)
  6. *1995 and 1997 Evaluation and Management Documentation Guidelines* are available on the CMS website at [www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)
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## **Medicare Learning Network Products for Physicians**

*Reference: CMS List-Serv Message 062806*

The *Facilitator's Guide*, which provides facilitators with everything needed to prepare for and conduct a Medicare Program training course and is a companion to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*, is now available in downloadable format on the MLN Publication Page located at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp> on the Centers for Medicare & Medicaid Services (CMS) website.

The *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* in CD-ROM format is available free of charge from the MLN Product Ordering Page located at <http://www.cms.hhs.gov/mlngeninfo/> on the CMS website.

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## **Medicare Details Steps Taken to Improve Customer Service by Drug Plans**

*Reference: CMS List-Serv Message 062906*

Since January, Medicare has taken more than 1,000 compliance actions to improve prescription drug plan service to beneficiaries, and in most cases, these actions have resulted in timely responses by the drug plans. Cases when plans did not resolve issues promptly have resulted in further enforcement actions to achieve compliance, such as restricting plans' ability to enroll beneficiaries. One plan with recurrent service problems has been placed on a track that may result in termination.

CMS will continue to monitor plans to assure that they maintain low wait times. Updated plan-by-plan reports on call center performance will be reported by CMS ahead of the next open enrollment period in the fall.

To view the entire press release, please click the following link:

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1890>

## Appropriate Billing with Modifier -59

Reference: MO-LSB062306

### The Problem

The Office of Inspector General (OIG) has identified errors in billing involving modifier -59. Use of this modifier is widespread and, in their study, 40% of the services billed with the modifier did not meet program requirements. It is therefore important for providers to be knowledgeable about these requirements so that services are billed appropriately by the provider and paid correctly by the Carrier.

- According to the CPT® book, Appendix A, modifier -59 represents a distinct procedural service. It states, “Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”
- Per the *Medicare Claims Processing Manual*, when correct coding edits indicate a modifier may be utilized, “the secondary, additional, or lesser procedure(s) or service(s)” (the code in the second column in the edits) “must be identified by adding the modifier -‘59’.”
- Per Section 1833(e) of the Social Security Act, providers must furnish “such information as may be necessary in order to determine the amounts due” to receive Medicare payment. Documentation is a very important part of the use of modifier -59.
- Per the *Medicare Claims Processing Manual*, modifier -59 may not be used with CPT 77427 (Radiation treatment management, five treatments) or with CPT 99201-99499 (Evaluation and Management Services).

### How do we determine whether a service is “normally reported together”?

CMS developed the Correct Coding Initiative (CCI) in January, 1996 “to promote national correct coding methodologies and to control improper coding. The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs.” These edits may be found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

They are listed in two parts (Component Codes and Mutually Exclusive Codes) for various specialty areas of coding. If the Modifier column indicates a “0”, no modifier is allowed and the code in the second column is either a component of the code in the first column or is mutually exclusive to the code in the first column. That means that these two codes should not be billed together on the same day by the same provider. If the Modifier column indicates a “1”, a modifier such as -59 is allowed, if appropriate. If the Modifier column indicates a “9”, it is not applicable, and the code pair may be billed together without a modifier. When modifier -59 is used, it must always be appended to the code in the second column.

Below are examples of each of the two charts for Surgery Integumentary System, Code Range 10000-19999, Effective Dates 4/1/06-6/30/06, Version 12.1.

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### Component Code Chart

| Column1/Column 2 Edits |          |                                |                |                            |  |
|------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1               | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date<br>*=no data | Modifier<br>0=not allowed<br>1=allowed<br>9=not applicable |
| 10021                  | 19290    |                                | 20020101       | *                          | 1  |
| 10021                  | 36000    |                                | 20021001       | *                          | 1  |
| 10021                  | 36410    |                                | 20021001       | *                          | 1  |
| 10021                  | 37202    |                                | 20021001       | *                          | 1  |
| 10021                  | 62318    |                                | 20021001       | *                          | 1  |
| 10021                  | 62319    |                                | 20021001       | *                          | 1  |
| 10021                  | 64415    |                                | 20021001       | *                          | 1  |
| 10021                  | 64416    |                                | 20030101       | *                          | 1  |
| 10021                  | 64417    |                                | 20021001       | *                          | 1  |

### Mutually Exclusive Code Chart

| Mutually Exclusive Edits |          |                                |                |                            |  |
|--------------------------|----------|--------------------------------|----------------|----------------------------|--|
| Column 1                 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date<br>*=no data | Modifier<br>0=not allowed<br>1=allowed<br>9=not applicable |
| 11010                    | 21240    |                                | 19980101       | *                          | 1  |
| 11010                    | 21242    |                                | 19980101       | *                          | 1  |
| 11010                    | 21243    |                                | 19980101       | *                          | 1  |
| 11010                    | 21244    |                                | 19980101       | *                          | 1  |
| 11010                    | 21245    |                                | 19980101       | *                          | 1  |
| 11010                    | 21246    |                                | 19980101       | *                          | 1  |
| 11010                    | 21247    |                                | 19980101       | *                          | 1  |
| 11010                    | 21248    |                                | 19980101       | *                          | 1  |
| 11010                    | 21260    |                                | 19980101       | *                          | 1  |

#### How do we determine if it is separate and distinct?

- This code pair may represent a different session: Manual Therapy Techniques (97140) and Therapeutic Activities (97530) are not bundled in the Component Codes. However, in the Mutually Exclusive Codes in the CCI edits, 97140 is listed in the first column and 97530 is listed in the second column with a modifier of “1”. They are not separate and distinct unless the medical record documents that the services were performed in different 15- minute time intervals, representing different sessions. In this case, the modifier -59 would be appended to the second column code (97530). If the provider/supplier was to bill Manual Therapy Techniques (97140) and Massage (97124) on the same date, they are bundled in the Component Codes with a modifier of “0”. Modifier -59 may not be appended to 97124 (the second code) because they are always bundled and cannot be billed together, even if they were performed in different 15-minute time intervals.
- This code pair may represent a different procedure or surgery: Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency (47370) and ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device; imaging supervision and interpretation) (76042), are normally bundled in the Component Code list with a modifier of “1”. They could be billed with modifier -59 on the 76042 code (in the second column) only if the ultrasonic guidance service is performed for a procedure

unrelated to or different than the surgical laparoscopic ablation procedure, and this is reflected in the medical record.

- This code pair may represent a different site: The bone marrow biopsy (38221) and bone marrow aspiration (38220) are normally bundled in the Component Code list with a modifier of “1”. However, they may have been performed at different sites such as the iliac crest and the sternum. In this case (if documented in the note) modifier -59 may be appended to the procedure in the second column of the CCI edits (38220), and the service would be allowed
- This code pair may represent a separate incision: An appendectomy (44950) and repair umbilical hernia, age 5 years or over; reducible (49585) are normally bundled. In the CCI edits, 44950 is listed in the first column and 49585 is listed in the second column of the Component Codes with a modifier of “1”. If they are performed through different incisions (and this is documented in the note), modifier -59 may be appended to the procedure in the second column of the CCI edits (49585), and the service would be allowed.
- This code pair may represent a separate lesion: A biopsy of the skin on the neck (11100) is performed in the same session as an excision of a 1.5 cm. benign lesion of the face (11442). These are bundled in the Component Code list with the 11442 in the first column, the 11100 in the second column, and a modifier of “1”. They may be billed with modifier -59 on the 11100, since the biopsy of the skin on the neck is documented as a separate lesion from the benign facial lesion.
- A procedure may be considered to be included in a more extensive procedure unless one of the above rules applies. For example, cardiovascular stress test with interpretation and report (93015) and rhythm ECG, one to three leads; with interpretation and report (93040) are normally bundled in the Component Code list with a modifier of “1”. The rhythm ECG services would only be allowed if performed unrelated to the stress test procedure at a different patient encounter because the ECG is normally a part of the stress test. In this case, if documented, modifier -59 could be appended to the 93040 code (the second code in the list), and it would be allowed.

Your state’s website displays flow sheets that provide a schematic representation of the process for use of modifiers including modifier -59 at:

|               |   |
|---------------|---|
| Arkansas:     | <a href="http://www.arkmedicare.com/provider/datanaly/modflow/default.htm">http://www.arkmedicare.com/provider/datanaly/modflow/default.htm</a>   |
| Louisiana:    | <a href="http://www.lamedicare.com/provider/datanaly/modflow/default.htm">http://www.lamedicare.com/provider/datanaly/modflow/default.htm</a>     |
| Missouri:     | <a href="http://www.momedicare.com/provider/datanaly/modflow/default.htm">http://www.momedicare.com/provider/datanaly/modflow/default.htm</a>     |
| Oklahoma:     | <a href="http://www.oknmmedicare.com/provider/datanaly/modflow/default.htm">http://www.oknmmedicare.com/provider/datanaly/modflow/default.htm</a> |
| New Mexico:   | <a href="http://www.oknmmedicare.com/provider/datanaly/modflow/default.htm">http://www.oknmmedicare.com/provider/datanaly/modflow/default.htm</a> |
| Rhode Island: | <a href="http://www.rimedicare.com/provider/datanaly/modflow/default.htm">http://www.rimedicare.com/provider/datanaly/modflow/default.htm</a>     |

Additionally, each state’s website has a web-based training course available for providers. Go to the website under Provider, then Publications, and then Web-based Training, to the course entitled *Modifiers*. This is a valuable resource for providers and their staff.

### **What is the role of documentation in appropriate modifier use?**

The provider is required to document and keep in the patient’s medical record all information that justifies the services rendered and to provide this documentation to Medicare upon request. This documentation must be legible and complete to show all procedures and services performed on that particular date. If medical records are requested, review must show that one of the above situations occurred, allowing the use of modifier -59. If it was not documented as a distinct and independent service in one of these ways, the claim will be denied.

### **What did the OIG find when they looked at modifier -59?**

For the period studied, the OIG found that 40% of the claims with modifier -59 did not meet the program requirements, resulting in \$59 million in improper payments. 15% of the services were not distinct, as they were performed at the same session, same anatomical site, and/or through the same incision. The other 25% of the services were not adequately documented, for one of the following reasons:

- The primary, secondary, or both services were not documented.
- A different code should have been billed for one or both of the services performed.

- The documentation was insufficient to make a determination (either thorough legibility issues or not sufficiently supporting the code billed).
- The documentation required was not provided at all for the date of service requested.

It was also found that at least 10% of the claims billed with modifier -59 were paid when the modifier was attached to the primary code only. These claims should only be paid when attached to the secondary code, raising questions about how the guidelines are applied within the Carrier's claims processing systems. The highest frequency code pairs generating the highest allowed dollars were the following: 17000/11100; 96410/90780; 97140/97530; and 96408/90780.

#### **Why is this significant to you, as a provider?**

“The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by these programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections...” Because of their previous findings, the OIG expects the Carrier to educate providers so that the program requirements are followed and the scenarios above will not occur in the future. It is an important issue as far as expended revenue in the Medicare System. Therefore, it will be closely watched by both the Carrier and the OIG to ensure that providers are following the program requirements and all standards related to the use of this modifier, including attaching the modifier to the secondary code in the code list.

#### **References:**

1. *Current Procedural Terminology* ©2005 American Medical Association. All Rights Reserved. CPT® is a trademark of the American Medical Association
2. Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29, Section 20.9, Correct Coding Initiative, which may be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>
3. Title XVIII of the *Social Security Act*, Section 1833(e)
4. *National Correct Coding Initiative*, which may be found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>
5. Department of Health and Human Services, Office of Inspector General, *Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits*, November, 2005, OEI-03-02-00771
6. CMS Modifier -59 Article, which may be found at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>

## Oasis<sup>®</sup> Wound Matrix - Provider Reimbursement Issues

Reference: AR – WRR 071906

Multiple inquiries have been received by your Medicare carrier, Pinnacle Business Solutions, Inc. (PBSI) regarding the use of the xenograft codes (CPT<sup>®</sup> 15400-15431) when the service provided is **application** of the OASIS<sup>®</sup> Wound Matrix.

The OASIS Wound Matrix “is a biologically derived extracellular matrix-based wound product comprised of porcine-derived acellular small intestine submucosa.”<sup>1</sup> Many of our physicians are coding CPT 15400-15420, but these are codes for **dermal xenografts**, and **would not be appropriate**. Medicare would not expect to see claims with these codes utilized for a collagen dressing. The literature from Healthpoint<sup>®</sup> (distributor for OASIS) indicates that physicians can now utilize CPT 15430 and 15431 for acellular xenograft implants (**infants and children**), but again, this product is not an acellular xenograft, but a **collagen based wound matrix dressing**, and **these codes would not be appropriate**. OASIS<sup>®</sup> is still **listed by the FDA as a Wound Dressing**<sup>2</sup> and in the August, 2005 FDA General and Plastic Surgery Devices Panel meeting of the Medical Devices Advisory Committee, the Cook Biotech representative still referred to OASIS<sup>®</sup> type products as “**wound dressings** with drug, biologic or animal based components.”<sup>3</sup>

Per the CPT code book regarding skin substitutes, “**these codes are not intended to be reported** for simple graft application alone or application stabilized with dressings (e.g., by simple gauze wrap) **without surgical fixation** of the skin substitute/graft. The skin substitute/graft is anchored using the surgeon’s choice of **fixation**.”

OASIS<sup>®</sup> is usually utilized following debridement of the wound. This could either be surgical debridement (CPT codes 11000-11044) or active wound management (CPT codes 97597-97598 or 97602-97606). All of these codes (with the exception of 97602) are payable by Medicare, if medically necessary for the care of the wound.

**Per Healthpoint<sup>®</sup> literature**, instructions for use of OASIS<sup>®</sup> are as follows:

- “1. Prepare wound area using standard methods to ensure wound is free of debris and necrotic tissue. An initial **surgical debridement** of the wound may be necessary to ensure the wound edges contain viable tissue.
2. **To apply**, cut the dry sheet (and place) it in a dry state over the wound and (re-hydrate) the sheet using sterile saline
3. **Place** the edge of **the sheet in contact** with the intact tissue. **Smooth OASIS<sup>®</sup> into place** to ensure the sheet is in contact with the underlying wound bed
4. **After application**, use an appropriate, non-adherent, **secondary dressing** to maintain a moist wound environment”<sup>1</sup>

The above description of **applying a dressing** does not meet the **surgical fixation rules** established in CPT, nor the intent of the xenograft or skin substitute codes. Pinnacle Medicare Services will pay for the debridement of the wound area or other wound care as appropriate, but the OASIS<sup>®</sup> Wound Matrix is considered a **dressing, not a xenograft**, and would fall under the supply rules.

It is correct to code J7341 for the OASIS<sup>®</sup> product as a supply, per CMS guidelines. Per the HCPCS Jurisdiction List, this particular supply (J7341) must be billed to the local carrier, rather than the DMERC. However, J7341 is a status E code – excluded from physician fee schedule by regulation, and therefore is **carrier priced** under reasonable charge procedures. Since it is considered a **collagen based wound matrix dressing**, per PBSI, it would be **included with** the other procedure(s) performed that date; i.e., Evaluation and Management Codes, Surgical Debridement, and/or or Active Wound Care Management codes.

Claims submitted to PBSI with procedure codes 15400-15431, for which documentation does not support a **true xenograft**, **will be denied**. J7341, the code for the OASIS<sup>®</sup> product, is **included** by the carrier into the other procedure(s) performed that date and **will not be paid separately**.

### References:

1. Information on the OASIS<sup>®</sup> Wound Matrix product may be found at:  
[www.healthpoint.com/divisions/tm/prodOASIS.cfm](http://www.healthpoint.com/divisions/tm/prodOASIS.cfm)
2. FDA listing is found at:  
[www.accessdata.fda.gov/scripts/cdrh/cfdocs/search/search.cfm?db=LST&ID=25391](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/search/search.cfm?db=LST&ID=25391)

3. Pertinent meeting minutes may be found on Index Page 60-66 at [http://google2.fda.gov/search?q=cache:dr7\\_cdpNvNoJ:www.fda.gov/ohrms/dockets/ac/05/transcripts/2005-4168t2.htm+Oasis+wound+matrix&access=p&output=xml\\_no\\_dtd&ie=UTF-8&lr=&client=FDA&site=FDA&proxystylesheet=FDA&oe=windows-1252](http://google2.fda.gov/search?q=cache:dr7_cdpNvNoJ:www.fda.gov/ohrms/dockets/ac/05/transcripts/2005-4168t2.htm+Oasis+wound+matrix&access=p&output=xml_no_dtd&ie=UTF-8&lr=&client=FDA&site=FDA&proxystylesheet=FDA&oe=windows-1252)
4. *Current Procedural Terminology* ©2005 American Medical Association. All rights reserved. CPT® is a trademark of the American Medical Association
5. OASIS® is a registered trademark of Cook Biotech, Inc.
6. Healthpoint.® is a registered trademark of Healthpoint Ltd., San Antonio, TX
7. HCPCS Jurisdiction list may be found at: <http://www.cms.hhs.gov/transmittals/downloads/R893CP.pdf>

## **CMS-1500 and 1490 (UB-92) Claim Form Revisions**

Reference: AR – GPH 072506

### **CMS 1500**

The Form CMS-1500 (12-90) is being revised to accommodate the reporting of the National Provider Identifier (NPI). The Form CMS-1500 (08-05) version will be effective October 1, 2006, but will not be mandated for use until February 1, 2007.

The following is the Form CMS-1500 form timeline:

- **October 1, 2006:** Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised Form CMS-1500 (08/05).
- **October 1, 2006 – January 31, 2007:** Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- **February 1, 2007:** The current Form CMS-1500 (12/90) version of the claim form is discontinued; only the revised Form CMS-1500 (08/05) is to be used. All rebilling of claims should use the revised Form CMS-1500 (08/05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12/90).

A summary of changes are listed below.

1. Appropriate NPI language has been added to Fields 17 and 17a
2. New Field 17b is introduced
3. Shaded area of Field 24, details 1-6 is introduced
4. New Field 24j is introduced
5. Appropriate NPI language has been added to Fields 32 and 33
6. New Fields 32a, 32b, 33a, and 33b are introduced

Additional information is available in the *Medicare Providers' News*, April 2006, page 6. The CMS Change Request is 4293. The change in the CMS-1500 is being coordinated by the National Uniform Claims Committee (NUCC), [www.nucc.org](http://www.nucc.org).

### **CMS 1490- UB 92 soon to become UB 04**

The National Uniform Billing Committee (NUBC) unveiled the new UB-04 form at its May 12, 2005, meeting, [www.nubc.org](http://www.nubc.org). The UB-04 contains a number of improvements and enhancements that resulted from nearly four years of research, including better alignment with the electronic HIPAA ASC X12N 837-Institutional transaction standard.

The UB-04 is scheduled to replace the UB-92 beginning with bills created on March 1, 2007 in accordance with the following transition:

- **March 1, 2007** – Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the new UB-04 form and data set.
- **March 1 to May 22, 2007** – Providers can use either the UB-04 or UB-92 forms/data set specifications.
- **May 23, 2007** – The UB-92 is discontinued; only the UB-04 form and data set specifications should be used. All rebilling of claims must use the UB-04 from this date forward, even though earlier submissions may have been on the UB-92.

### **Administrative Simplification Compliance Act (ASCA) (Public Law 107-105)**

Reminder for the Mandatory Electronic Submission of Medicare Claims

#### ***Providers Affected***

All Medicare providers (except small providers). See below for more information on small providers

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

Unless you qualify as a small provider, your initial claims to Medicare must be submitted electronically as of October 16, 2003, or Medicare may not cover them.

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

The Administrative Simplification standards of the Health Insurance Portability and Accountability Act (HIPAA) and the Administrative Simplification Compliance Act (ASCA) impact how your claims must be submitted to Medicare. This article provides important highlights for you.

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

You should make sure that your billing staffs are aware of these requirements to submit claims to Medicare electronically. Additionally, you should make sure that your process of electronic submission is HIPAA compliant. The law and regulation permit a number of exceptions to the electronic billing requirement. Although electronic submission is encouraged, Medicare will continue to accept paper claims when any of the following apply:

1. FI small providers - To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs). Carrier small providers - To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than 10 FTEs;
2. Dentists;
3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;
4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;
5. Providers that submit claims for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as Payment in Full (OTAF) adjustment;
6. Providers of home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO<sub>2</sub> is more than 60 mmHg;
7. Those few claims that may be submitted by beneficiaries;
8. Providers that only furnish services outside of the United States;
9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
10. Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically.

### ***Related Instructions***

Please refer to the following sections of the Medicare Claims Processing Manual (IOM 100-4, Chapter 24 - EDI Support Requirements) for additional information:

- 90 - Mandatory Electronic Submission of Medicare Claims
- 90.1 - Small Providers and Full-Time Equivalent Employee Assessments
- 90.2 – Exceptions
- 90.3 - "Unusual Circumstance" Waivers
- 90.3.1-Unusual Circumstance Waivers Subject to Provider Self- Assessment
- 90.3.2 - Unusual Circumstance Waivers Subject to Medicare Contractor Approval
- 90.3.3 - Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision
- 90.4 - Electronic and Paper Claims Implications of Mandatory Electronic Submission
- 90.5 – Enforcement

You may view the actual chapter of this manual by going to:

<http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf>

Or, you may view the relevant excerpts of that chapter within the actual Change Request issued to Medicare carriers and intermediaries by going to:

<http://www.cms.hhs.gov/transmittals/downloads/R44CP.pdf>

These documents have additional details on exceptions and waivers, especially how to request a waiver. They also contain more details on how small providers and FTE totals are determined.

Should you have additional questions, please contact your carrier or intermediary on their toll-free number. If you do not have that number, you may find it at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

## ***Medicare Administrative Contractor (MAC)***

### **A/B MAC NEWS #1 - First Contract for a Part A/Part B Medicare Administrative Contractor (MAC) To Be Awarded in Near Future**

*Reference: Medlearn Matters Number: SE0642*

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

All Medicare physicians, providers, and practitioners that bill Medicare fiscal intermediaries (FIs) or carriers for their services, especially those in the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming

#### ***Background***

Section 911 of the Medicare Modernization Act (MMA) requires the Secretary to implement Medicare Contracting Reform by 2011. The law mandates that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by fiscal intermediaries and carriers in administering the Medicare fee-for-service program.

Medicare Contracting Reform will:

- Improve administrative services within the fee-for-service claims processing environment by reducing the number of contracts, focusing on correct claims payment and creating performance incentives related to timeliness, accuracy, and quality of services to CMS and to providers of services to Medicare beneficiaries;
- Lead to more efficiency and greater accountability among companies performing claims administration and provider education, and services by promoting competition and basing awards on good performance;
- Generate operational savings to the federal government and taxpayers through consolidation and competition of large and high value contracts

With Medicare Contracting Reform, providers of health care in the original Medicare program can expect:

- Better educational and training resources on correct claims submission, Medicare coverage rules, and Medicare payment rules;
- Easier communications with a single A/B MAC serving as the point-of-contact for both Part A and Part B claims administration and payment;
- Increased payment accuracy and consistency in payment decisions resulting from CMS' increased focus on financial management by MACs; and
- An opportunity for input in evaluation of their MAC's performance through satisfaction surveys conducted by CMS.

#### ***Key Points for Providers***

CMS soon will announce the result of the first full and open competition for a Part A/Part B Medicare Administrative Contractor (A/B MAC) conducted as part of the agency's Medicare Contracting Reform implementation strategy. This award will be for a single fee-for-service claims processing contract that will combine the workloads for a multi-state jurisdiction currently serviced both by FIs and carriers.

This first A/B MAC award will be for Jurisdiction 3, which includes the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. Jurisdiction 3 represents three percent of the national fee-for-service Medicare claims volume.

With this contract award, CMS will begin to achieve efficiencies and administrative savings through the consolidation of the traditional cost-reimbursable contracts and by implementing improved contracting processes quickly.

The Request for Proposal (RFP) for the Jurisdiction 3 A/B MAC was released in September 2005. Full implementation of the new contractor is scheduled for July 2007. CMS will work with the current carriers and FIs in Jurisdiction 3, whose contracts will end with the MAC implementation, to ensure a smooth transfer of records and information to the new Jurisdiction 3 A/B MAC.

The carriers and FIs whose contracts will end are Montana Blue Cross Blue Shield, Wyoming Blue Cross, Arizona Blue Cross, and Noridian Administrative Services. CMS recognizes with gratitude the strong commitment by these corporations to serving the Medicare program for more than 40 years.

The Jurisdiction 3 A/B MAC contract award will be the first of 15 A/B MAC contracts. Each of these contracts will be for the administration of both the Medicare Part A and Part B benefits in a specified geographic jurisdiction of the country. (See the *Additional Information* section of this article for the web page containing a map showing the 15 jurisdictions.) All 15 contracts are to be awarded, and all A/B MACs are to be operational, by October 2011.

CMS has extensive experience in overseeing the successful transfer of Medicare claims processing work from one contractor to another. The agency is committed to ensuring that the implementation of the new A/B MAC environment will be as seamless as possible for the Medicare providers and beneficiaries.

CMS will devote full resources and manage the A/B MAC contract implementation so as to ensure continuity, accuracy, and timeliness in claims processing and issuance of payments. In Jurisdiction 3, CMS plans to implement the new A/B MAC contract by transferring the claims processing workload from the current contractors incrementally (rather than all at once) to ensure that neither providers nor beneficiaries will be adversely affected.

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

Information on the Jurisdiction 3 A/B MAC procurement, including the scope of work to be performed, is available on the Federal Business Opportunities web site at:

<http://www1.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2005%2D0016/Attachments.html>

A map displaying the 15 A/B MAC jurisdictions is available on the Medicare Contracting Reform web site at [http://www.cms.hhs.gov/MedicareContractingReform/05\\_A\\_BMACJurisdictions.asp#TopOfPage](http://www.cms.hhs.gov/MedicareContractingReform/05_A_BMACJurisdictions.asp#TopOfPage) on the CMS web site. Individual fact sheets and data on each jurisdiction are also available there.

Suppliers may want to consult *MLN Matters* article SE0628 to see how Medicare Contracting Reform affects durable medical equipment regional carriers (DMERCs). That article is available on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf>

## Medicare Secondary Payer (MSP)

### Modification to Online Medicare Secondary Payer Questionnaire; Full Replacement of and Rescinding CR 3504

Reference: *Trans. 41, CR #4098, Pub. 100-05, Medlearn Matters Number: MM4098*

**Note:** This article was revised on June 15, 2006, because CR4098, on which this article is based, has been superseded by CR5087. To view modifications to the online Medicare Secondary Payer Questionnaire that are effective as of September 11, 2006, please see MLN Matters article MM5087, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf> on the CMS web site.

#### *Provider Types Affected*

Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare

#### *Impact to You*

CR4098 clarifies recent changes made to the “Medicare Secondary Payer Questionnaire.”

#### *What You Need to Know*

This CR identifies all of the changes that were made to CR3504 **and** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

#### *What You Need to Do*

Please refer to the *Background and Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified.

#### *Background*

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR3504) did not specifically mention all of the changes that were made to the “Medicare Secondary Payer (MSP) Questionnaire.” CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR4098, provides a model: “Admission Questions to Ask Medicare Beneficiaries.”

The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV and V** of the model questionnaire adds the response: “No, Never Employed.”
- In **Parts IV, V, and VI** of the model questionnaire, providers should use “Policy Identification Number” to mean a number that is sometimes referred to as the health insurance benefit package number.
- **Parts IV, V, VI** of the model questionnaire adds “Membership Number” and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses “spouse” instead of “family member.”
- **Part V**, question 4 changes the model questionnaire to read:  
*Are you covered under the group health plan of a family member other than your spouse?*  
\_\_\_\_ Yes \_\_\_\_ No  
*Name and address of your family member’s employer:* \_\_\_\_\_
- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI**, question 6 now reads: “Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?”

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

### ***Implementation***

The implementation date for the instruction is January 21, 2006.

### ***Additional Information***

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

<http://www.cms.hhs.gov/transmittals/downloads/R41MSP.pdf>

If you have 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>

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## **New Medicare Secondary Payer (MSP) Balancing Edits**

*Reference: CR4261; LA – FM 063006*

Effective August 7, 2006, inbound 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

Effective July 3, 2006, 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 is 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 were deleted July 3, 2006 to allow for negative values in CAS Adjustment Amount fields.

## National Provider Identifier (NPI)

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

Reference: CR 4023; LA – 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.

| <u>Edit Number</u> | <u>Loop</u> |
|--------------------|-------------|
| M362               | 2010AA      |
| M363               | 2010AB      |
| M364               | 2310A       |
| M365               | 2310B       |
| M366               | 2310C       |
| M367               | 2310E       |

M373 2420A  
M374 2420B  
M375 2420D  
M376 2420E  
M377 2420F

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

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

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## 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/](http://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.

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## Announcement of a Dedicated National Provider Identifier (NPI) Web Page

*Reference: JSM CI 4048-06536, 07-05-06*

CMS has established a dedicated National Provider Identifier Web page that houses all NPI outreach information that CMS has prepared, as well as links to other NPI-related documents of interest to health care providers. The page also has information that is explicitly for use by Medicare enrolled providers so that Medicare's implementation information and expectations are available to enrolled providers (<http://www.cms.hhs.gov/NationalProvIdentStand/>). Providers can also find valuable NPI information at the following Web site: <https://nppes.cms.hhs.gov>

## Stage 2 National Provider Identifier (NPI) Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 • Remittance Advice

Reference: Trans. 996, CR #5081, Pub. 100-04, Medlearn Matters Number: MM5081

### Provider Types Affected

All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs))

### Background

This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs).

Medicare has published CR4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006:** Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007:** Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward:** Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

### Key Points

**During Stage 2**, if an NPI is received on the claim, it will be cross walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

|                      |               |                 |                                  |
|----------------------|---------------|-----------------|----------------------------------|
| <b>Scenario I:</b>   | Single NPI    | cross walked to | Single legacy number             |
| <b>Scenario II:</b>  | Multiple NPIs | cross walked to | Single Medicare legacy number    |
| <b>Scenario III:</b> | Single NPI    | cross walked to | Multiple Medicare legacy numbers |

**Note:** The Standard Paper Remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy numbers but and different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents will be updated to reflect these changes and the updated documents will be posted on the CMS web site at:

**Scenario I – Single NPI cross walked to single legacy number:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level. if needed.
3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

**Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. SPR: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Implementation**

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

**Additional Information**

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

<http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf>

The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR5081.

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

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

The MLN Matters article that provides additional information about Stage 1 Use of NPI is at the following address is available on the CMS web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf>

## Preventive Services

### Medicare Provides Coverage for Many Preventive Services and Screenings

Reference: Medlearn Matters Number: SE0630

**Note:** This article was revised on June 30, 2006, to remove references to the “Flu Billing” Videos, which are no longer available on the CMS web site.

#### **Provider Types Affected**

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

#### **Provider Action Needed**

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

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

#### **Introduction**

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

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

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

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

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

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

### **Educational Products and Informational Resources for Health Care Professionals**

CMS has developed a variety of educational products to:

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

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

### **Product Ordering Instructions**

To order a product, free of charge, click here: **Order Product**.

### **Brochures**

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

- *Adult Immunizations* [http://www.cms.hhs.gov/MLNProducts/downloads/adult\\_immunization\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization_06-08-05.pdf)
- *Bone Mass Measurements* [http://www.cms.hhs.gov/MLNProducts/downloads/bone\\_mass\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.pdf)
- *Cancer Screenings* [http://www.cms.hhs.gov/MLNProducts/downloads/cancer\\_screening\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening_06-08-05.pdf)
- *Expanded Benefits* [http://www.cms.hhs.gov/MLNProducts/downloads/expanded\\_benefits\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits_06-08-05.pdf)
- *Glaucoma Screening* [http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma_06-08-05.pdf)
- *Smoking and Tobacco-Use Cessation Counseling Services*  
<http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf>

### **Guides**

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

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

### **Medicare Preventive Services CD ROM**

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

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

### **Quick Reference Information Chart**

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

[http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_prevent\\_serv.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_prevent_serv.pdf)

### **Web-Based Training Courses**

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

### **Web Page**

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

### **Other Useful Provider Resources**

Other useful provider resources include the following:

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

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

### **CMS Prevention Web Pages**

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

### **Medicare Learning Network (MLN)**

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

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

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

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

### **Preventive Benefit Information for Medicare Beneficiaries**

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

## *Provider Enrollment*

### **Provider Enrollment Applications**

*Reference: LA – KSG 071806*

The CMS-855 Medicare enrollment applications located on the CMS forms web page can be completed on-line in a PDF fillable format or downloaded and completed by hand. All the CMS 855 forms have been posted to the CMS Forms Internet website <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage> (note: the Provider Enrollment website has a reference link "All CMS Forms" which takes you to the main CMS Forms list link above, but does not link directly to each individual form.)

The direct link for each form follows:

- CMS 855A (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>
- CMS 855B (06/06) <http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf>
- CMS 855I (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf>
- CMS 855R (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf>
- CMS 855S (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf>

## *Psychological Services*

### **Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Clinical Psychologist Services**

*Reference: Trans. 51, CR #4400, Pub. 100-02, Medlearn Matters Number: MM4400*

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

Physicians, providers, and/or clinical psychologists who submit claims to Medicare carriers, for diagnostic psychological testing services

#### ***Impact on Providers***

- CR4400 alerts providers that Medicare may now pay for the services of a clinical psychologist when they supervise the performance of diagnostic psychological testing.
- Under the physician supervision level of four, Medicare's physician supervision policy is modified so the policy does not apply when the procedure is furnished under the general supervision of a clinical psychologist.
- Medicare carriers are not required to retroactively process claims for the period between January 1, 2005, and the implementation date. Carriers are to reprocess claims that are brought to their attention that have been denied with dates of service on or after January 1, 2005.

#### ***Background***

Diagnostic psychological testing may now be performed under the general supervision of a clinical psychologist. This change may be found in the revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Section 160 - Clinical Psychologist Services.

As a reminder, to qualify as a clinical psychologist (CP), a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology; and
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

#### ***Implementation***

The implementation date for this instruction is September 21, 2006.

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

The revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Sections 80 and 160 - Clinical Psychologist Services, is attached to CR4400, which is the official instruction issued to your carrier regarding this change. CR 4400 may be found by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R51BP.pdf>

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/apps/contacts/>

## Remittance Advice

### Ending the HIPAA Contingency for Remittance Advice

Reference: *Medlearn Matters Number: SE0646*

#### **Provider Types Affected**

All providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs))

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

Effective October 1, 2006, Medicare will send only HIPAA-compliant Electronic Remittance Advice (ERA) transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.

#### **Background**

In 2003, the Centers for Medicare & Medicaid Services (CMS) addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance;
- Assess the readiness of their provider communities; and
- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed **inbound** claims on October 1, 2005, and at that time began denying non-compliant electronic claims.

Now, CMS is moving to end the contingency plan for Electronic Remittance Advice (ERA) transactions. Currently, 99% of all Electronic Remittance Advice (ERA) receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA.

Further, the overall compliance rate for all Medicare providers in May, 2006, was 96%. (The rate for professional providers was 97% and for institutional providers was 93%.)

Therefore, CMS announces that, effective October 1, 2006 it will end the contingency plan for the remittance advice transaction.

After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (transaction 835) to all electronic remittance advice receivers. In doing so, Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

#### **Additional Information**

You can find more information about HIPAA on the CMS web site at:

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

If you have any questions, please contact your Medicare contractor 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 Remit Easy Print (MREP) Version 1.8 is Now Available for Download

*Reference: JSM CI 4004-06497, 06-15-06*

Version 1.8 includes many improvements, including the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as:

- A new Coordination of Benefits (COB) report showing claims that were crossed over;
- An import functionality for the Claim Adjustment Reason Codes and Remittance Advice Remark Code updates, so a full version does not need to be reinstalled for code updates only;
- An enhanced search functionality, including for the date of service;
- An enhanced Deductible/Coinsurance report to show both deductible and coinsurance amounts greater than zero, as well as those claims with only the coinsurance dollar amount greater than zero;
- More claim detail on the reports;
- When a service line is denied, the number of submitted units will display. The paid units will display when a service line is paid;
- Display of check date instead of 835 production transaction date; and
- A late filing charge correction

In addition, there are some changes to the User Guide and install/uninstall instructions. Remember you can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!

## Telehealth Services

### Medicare Telehealth Services Update

Reference: Trans. 997 and 53, CR #5122, Pub. 100-04 and 100-02, Medlearn Matters Number: MM5122

#### Provider Types Affected

Providers who bill Medicare carriers and fiscal intermediaries (FIs) for telehealth services

#### Impact to You

When billing for telehealth services provided on or after January 1, 2006, do not use current procedure terminology (CPT) codes 99261-99263 (hospital inpatient follow-up consultations) or 99271-99275 (confirmatory consultations). These codes no longer exist, and using them could impact your reimbursement.

#### What You Need to Know

The American Medical Association has deleted CPT codes 99261 – 99263 (hospital inpatient follow-up consultations) and codes 99271 - 99275 (confirmatory consultations). Effective January 1, 2006, these CPT codes no longer exist and were removed from the physician fee schedule.

#### What You Need to Do

Make sure that your billing staffs are aware that CPT codes 99261- 99263 and 99271-99275 are no longer usable for telehealth services.

#### Background

CR5122, from which this article is taken, is issued to alert you that, effective January 1, 2006, the AMA has deleted the following CPT codes:

- 99271 – 99275 (Confirmatory consultation); and
- 99261 – 99263 (Follow-up inpatient consultation).

Thus, the CPT codes that describe these services (hospital inpatient follow-up consultations – 99261 through 99263 and confirmatory consultations – 99271 through 99275) no longer exist.

In response, also effective January 1, 2006, CMS has removed confirmatory consultation and inpatient follow-up consultation from the list of Medicare telehealth services as referenced in the *Medicare Benefit Policy Manual* (Publication 100-02) and the *Medicare Claims Processing Manual* (Publication 100-04). The relevant sections of these Manuals (Publication 100-02, Chapter 15, Section 270.2 [List of Medicare Telehealth Services] and Publication 100-04 Chapter 12, Section 190.3 [List of Medicare Telehealth Services]) have been revised to reflect these policy changes.

As displayed in Table 1 below, office and other outpatient consultations and initial inpatient consultations are included in Medicare telehealth consultations as described by CPT codes 99241 through 99255. The table displays the current Medicare telehealth services and CPT and HCPCS codes.

**Table 1: Current Medicare Telehealth Services and Associated CPT/HCPCS Codes**

| Service   | CPT/HCPCS Codes  |
|---|--|
| Consultations                                   | 99241 - 99255 as of January 1, 2006                        |
| Office or other outpatient visits               | 99201 - 99215  |
| Individual psychotherapy                        | 90804 - 90809  |
| Pharmacologic management                        | 90862  |
| Psychiatric diagnostic interview examination    | 90801  |
| End Stage Renal Disease (ESRD) related services | G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 |
| Individual Medical Nutrition Therapy            | G0270, 97802, and 97803                                    |

#### Additional Information

You can find more information about current Medicare telehealth services and the associated CPT/HCPCS codes in CR 5122, located at <http://cms.hhs.gov/Transmittals/downloads/R53BP.pdf> for the changes to Publication

100-02, Chapter 15, Section 270.2 (List of Medicare Telehealth Services) and at <http://www.cms.hhs.gov/Transmittals/downloads/R997CP.pdf> for the changes to Publication 100-04, Chapter 12, Section 190.3 (List of Medicare Telehealth Services).

If you have any questions, please 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>

## Therapy Services

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

Reference: Trans. 980 and 55, CR #4014, Pub. 100-04 and 100-03, Medlearn Matters Number: MM4014

**Note:** This article was revised on June 15, 2006, to reflect changes made to CR4014, which was re-issued on June 14, 2006. The transmittal number, CR release date, and the Web address for viewing CR4014 were revised. All other information remains the same.

#### **Provider Types Affected**

Physicians, suppliers, and providers billing Medicare carriers including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), for therapy services

#### **Impact to You**

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

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

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

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

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

#### **Background**

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

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

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

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

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

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

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

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

- Will occur on prepay or post-pay review. For example, compare the following:

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

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

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

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

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

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

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

### **Implementation**

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

### **Additional Information**

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

[http://www.cms.hhs.gov/manuals/pm\\_trans/R36BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf)

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

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

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

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

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

<http://www.cms.hhs.gov/Transmittals/downloads/R980CP.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>

## Therapy Caps Exception Process

Reference: Trans. 52, 140, 855 and CR #4364, Pub. 100-02, 100-08, 100-04, Medlearn Matters Number: MM4364

**Note:** This article was revised on July 3, 2006, to modify the transmittal number and Web address for the change made to the *Medicare Benefit Policy Manual*. All other information remains the same.

### *Provider Types Affected*

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services

### *Key Points*

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). Outpatient rehabilitation services include:
  - Ø **Physical therapy** - including outpatient speech-language pathology: Combined annual limit for 2006 is \$1,740; and
  - Ø **Occupational therapy** - annual limit for 2006 is \$1,740.
- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Ø Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap; or
  - Ø Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.
- Medicare beneficiaries may be manually exempted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.
- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

### *Background*

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of \$1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

## ***Additional Information***

### **Billing Guidelines**

- **KX Modifier:** You must include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests:** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care:** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using the KX modifier. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

### **ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity**

The CR4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available on the CMS web site at:

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

You may wish to bookmark that link so you may easily reference these codes.

### **Documentation**

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02 Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR4364. CR4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS web site;
- The *Medicare Claims Processing Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>; and
- The *Medicare Program Integrity Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** - 1-2 documents.
2. **Certification** - Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds 10 treatment days or 30 days) – These must be sufficient to explain the beneficiary’s current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not

required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.

4. **Treatment Encounter Notes** – The Treatment Encounter Note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for Progress Reports if they contain the requirements of interval progress reports at least once every 10 treatment days or once in the interval.
5. For therapy caps exceptions purposes, **records justifying services over the cap**, either included in the above or as a separate document.

Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary;
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation;
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service; and
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

### Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

**Note:** If your Medicare contractor does *not* make a decision within 10 business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed **approved** as medically necessary for the number of future visits requested (not to exceed 15).

### Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR4364. The examples include:

- Letter #1 - Approved
- Letter #2 - Negative Decision-Medical Necessity

- Letter #3 - Denied-Insufficient Documentation

### **Revised Medicare Summary Notice (MSN) Messages**

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR4364.

Once again, there are three transmittals that comprise CR4364. They are:

- The *Medicare Benefit Policy Manual* revision at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS web site;
- The *Medicare Claims Processing Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS web site;
- The *Medicare Program Integrity Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site.

If you have any questions, contact your Medicare contractor at their toll free number, which is available on the CMS web site at:

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



# Medicare Web-Based Training

**Q: How can I learn more about Medicare?**

**A: Medicare Web-Based Training!**

**Top Five Reasons You Should Utilize Web-Based Training Is:**

1. **Flexible** Medicare Web-based training is available 24 hours a day, 7 days a week.
2. **Cost-effective** The training is free.
3. **Time Saver** Complete courses in the comfort of your home or office.
4. **Interactive** Utilizes a multi-sensory approach to engage the learner.
5. **In Demand** Over 95% of learners report they are very satisfied with the quality of the courses.

As your Medicare Carrier, we are constantly seeking innovative ways to keep you informed and knowledgeable regarding Medicare policies and procedures. With that in mind, we now offer web-based training to the provider community at no charge.

**Current Topics**

- 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            | <a href="http://www.arkmedicare.com/provider/wbt">www.arkmedicare.com/provider/wbt</a>   |
| Louisiana           | <a href="http://www.lamedicare.com/provider/wbt">www.lamedicare.com/provider/wbt</a>     |
| Missouri            | <a href="http://www.momedicare.com/provider/wbt">www.momedicare.com/provider/wbt</a>     |
| Oklahoma/New Mexico | <a href="http://www.oknmmedicare.com/provider/wbt">www.oknmmedicare.com/provider/wbt</a> |
| Rhode Island        | <a href="http://www.rimedicare.com/provider/wbt">www.rimedicare.com/provider/wbt</a>     |



## Pinnacle Medicare Services Seminar Registration

Registering for Medicare seminars just became easier. You can register online or, you can use this form to register by mail for Medicare seminars presented by each office within the Pinnacle consortium. Please complete all of the requested information and mail the form to the address indicated below for your state:

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

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Seminar Number: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_

Number of attendees: \_\_\_\_\_ x \$30.00 per person = \$ \_\_\_\_\_ Total Amount Enclosed  
*(fees for seminars/workshops are non-refundable)*

Make checks or money orders payable to *Pinnacle Medicare Services*. We cannot accept cash or credit cards. Also note, for accounting purposes, we request that you submit payment for seminars/workshops separate from overpayment refunds.

Attendee Name(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**How many physicians/practitioners are the above attendees representing?:** \_\_\_\_\_

Office/Physician's Name: \_\_\_\_\_

Contact Name(s): \_\_\_\_\_ Provider Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Please keep a copy of this form for your records**

## Have a Question?

Your questions are important to us! In our continuing effort to expand the communication between Medicare and the Part B providers, we have established an "And The Answer Is....." column for our providers. If you have a question about Medicare Part B policies and regulations, you may use the form shown below. We will print the most commonly asked questions with their answers. Questions not printed in the newsletter will be addressed through written or telephone response, so be sure to include your name, address and telephone number.

### ***"Did You Know?" Question Submission Form***

Provider/Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Provider Number: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Telephone Number:( \_\_\_\_\_ ) \_\_\_\_\_

Question: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Question submission forms should be sent to:

Pinnacle Medicare Communications  
12755 Olive Blvd.; Suite 105  
Creve Coeur, MO 63141

## Your Feedback is Greatly Appreciated!

We would like to take this opportunity to ask you for your input about our service to you and how you think we can improve. Please take a few moments to answer the questions below. Your response will help us serve you better in the future. All comments, concerns and suggestions are welcome.

We suggest you make a copy of this form so that you may use it after any contact with our office (good or bad) on which you would like to comment. After completing the form, mail it to the Pinnacle Medicare Service office you had contact with. Here are the addresses to mail this form:

### Arkansas

Pinnacle Medicare Services  
Attn: Greg Hart  
P.O. Box 1418  
Little Rock, AR 72203

### Louisiana

Pinnacle Medicare Services  
Attention: Kim Gassie  
P.O. Box 83760  
Baton Rouge, LA 70884

### Missouri

Pinnacle Medicare Services  
Attention: Greg Hart  
P.O. Box 1418  
Little Rock, AR 72203

### New Mexico

Pinnacle Medicare Services  
Attention: Kim Gassie  
P.O. Box 83760  
Baton Rouge, LA 70884

### Oklahoma

Pinnacle Medicare Services  
Attention: Kim Gassie  
P.O. Box 83760  
Baton Rouge, LA 70884

### Rhode Island

Pinnacle Medicare Services  
Attention: Greg Hart  
P.O. Box 1418  
Little Rock, AR 72203

### Medicare Program:

Every day our staff makes numerous contacts with the provider community. Please comment on any contact you have had with our office that you would like us to know about. We appreciate being notified of any contact with an employee that meets your standard of excellence or any employee that falls below that standard.

Date of contact: \_\_\_\_\_ Contact was made: In person \_\_\_\_\_ By telephone \_\_\_\_\_

Name of Pinnacle employee that assisted you: \_\_\_\_\_  
(Employees should answer with their name.)

Provide us with a general description of the topic discussed or question(s) you asked.

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

Was our response clear and easy to understand? \_\_\_\_\_

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

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

General comments: \_\_\_\_\_

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

### Interactive Voice Response Unit:

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

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

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

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

What features do you feel you and your staff would use which are not available?

(Please remember, we cannot verify entitlement or deductible status through the IVR.)

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

*(continued on next page)*





## ***Arkansas Information***

*This information only applies to Medicare Part B providers in Arkansas. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 345-0274.*

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**THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME**



***Louisiana Information***

*This information only applies to Medicare Part B providers in Louisiana. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 567-8419.*

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**THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME**



**Missouri Information**

*This information only applies to Medicare Part B providers in Missouri. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 736-0799.*

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**THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME**



## ***Oklahoma/New Mexico Information***

*This information only applies to Medicare Part B providers in Oklahoma and New Mexico. If you have any questions regarding the information in this section, please call (877) 280-6520.*

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**THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME**



***Rhode Island Information***

*This information only applies to Medicare Part B providers in Rhode Island. If you have any questions regarding the information in this section, please call (866) 801-5304.*

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**THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME**



**Important Information from Your Medicare Part B Carrier**

**This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Additional copies of this and all newsletters are available at no cost from your state’s web site listed below.** Remember that this newsletter, as well as all other Medicare publications, serves as your official notice of Medicare coverage and billing information. Here is a list of phone numbers to call with questions about the information included in this newsletter. You must call the Customer Service area in the state where you are a Medicare provider. Be sure to check our web sites for the most up-to-date information:

- Arkansas ..... (866) 345-0274 ..... [www.arkmedicare.com](http://www.arkmedicare.com)
- Louisiana ..... (866) 567-8419 ..... [www.lamedicare.com](http://www.lamedicare.com)
- Missouri..... (866) 736-0799 ..... [www.momedicare.com](http://www.momedicare.com)
- Oklahoma ..... (866) 280-6520 ..... [www.oknmmedicare.com](http://www.oknmmedicare.com)
- New Mexico..... (866) 280-6520 ..... [www.oknmmedicare.com](http://www.oknmmedicare.com)
- Rhode Island..... (866) 801-5304 ..... [www.rimedicare.com](http://www.rimedicare.com)

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

*Medicare Provider News*, together with occasional “*Bulletins*” and “*Policy Notices*,” serves as legal notice to providers concerning responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines.

Editor: Scott Thier, Coordinator  
Medicare Communications

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

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