# 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:**

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

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

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

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

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

Name:______________________________________________________________________

Attn:_______________________________________________________________________

Provider Number (if applicable):____________________ Telephone:__________________________________

Street Address (include zip):______________________________________________________

___________________________________________________________________________

___________________________________________________________________________

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

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

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

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

## Paper Distribution of Medicare Providers' Newsletter

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

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

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

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

Name:________________________________________________________________

Attn:__________________________________________Telephone: __________________

Provider Number (if applicable):___________________E-Mail Address: _____________________

Street Address (include zip):_____________________________________________

_____________________________________________________________________

Reason: _____________________________________________________________

_____________________________________________________________________

Indicate bulletin preference(s): ___ Part B Newsletters & Policy Notices

___ Part A Newsletters & Policy Notices

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

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

## *Alert*

# GO ELECTRONIC $$$

## Save Administrative Dollars Today!

## Pinnacle Medicare Services Electronic Data Interchange

## Contact our EDI Team at:

## 1-866-582-3247

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

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

**Electronic Claims Filing**

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

**Medicare Claims Express (MCE)**

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

**Electronic Remittance Advice (ERA)**

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

**Medicare Remit Easy Print (MREP)**

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

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

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

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

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

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

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

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

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

**Electronic Funds Transfer (EFT)**

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

**Need More Information?**

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

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

Medicare web site:

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

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

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

## 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

## Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500

*Reference: Trans. 1010, CR #5060, Pub. 100-04, Medlearn Matters Number: MM5060*

***Provider Types Affected***

Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500

***Key Points***

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

| | |
|---|---|
| **January 2, 2007 – March 30, 2007** | Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. **Note:** Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007. |
| **April 2, 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. **Note:** 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). |

***Background***

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

*Billing Guidelines*

- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be **rejected** (in most cases with reason code 16 – "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information, **if**
- The **NPI** of the billing provider or group is **not entered** on Form CMS-1500 (08-05) in items:
  - Ø **24J** (replacing item 24K, Form CMS-1500 (12-90));
  - Ø **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - Ø **32a** (replacing item 32, Form CMS-1500 (12-90)); and
  - Ø **33a** (replacing item 33, Form CMS-1500 (12-90)).

*Additional Information*

**When the NPI Number is Effective and Required (May 23, 2007)**

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

**Additional NPI-Related Information**

Additional NPI-related information can be found on the CMS web site at:

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

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at:

http://www.nucc.org/images/stories/PDF/change_log.pdf

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found on the CMS web site at:

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

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found on the CMS web site at:

http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf

MLN Matters article MM4023, "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," can be found on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going on the CMS web site to:

http://www.cms.hhs.gov/Transmittals/downloads/R1010CP.pdf

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

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

## Non-Application of Deductible for Colorectal Cancer Screening Tests

*Reference: Trans. 1004, CR #5127, Pub. 100-04, Medlearn Matters Number: MM5127*

***Provider Types Affected***

Physicians and providers who provide colorectal cancer screening services to Medicare beneficiaries

***Impact on Providers***

Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes listed in the following chart. While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests.

| HCPCS Screening Code | Code Description |
| --- | --- |
| G0104 | Colorectal cancer screening: Flexible sigmoidoscopy |
| G0105<br><br>G0121 | Colorectal cancer screening: Colonoscopy on individual at high risk;<br><br>Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk |
| G0106 | Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy |
| G0120 | Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy |

**Currently** (prior to January 1, 2007, for colorectal cancer screening test services furnished before January 1, 2007), **the annual Medicare Part B deductible AND coinsurance apply to the above codes**.

Please note that the annual Medicare Part B deductible and coinsurance **do not apply** for the following tests.

- **G0107** (colon cancer screening; fecal occult blood tests (FOBT), 1-3 simultaneous determinations); and
- **G0328** (colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations).

***Background***

This policy is directed by Section 5113 of the Deficit Reduction Act (DRA) of 2005. It amends Section 1833(b) of the Social Security Act (SSA) by eliminating the requirement of the annual Part B deductible for colorectal cancer screening tests furnished on or after January 1, 2007.

***Additional Information***

SE0613 “Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening” contains pertinent information. It can be found on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf

This special edition also includes links to other resources related to colorectal cancer screening and Medicare-covered preventive services.

The manual attachment to CR5127 (*Medicare Claims Processing Manual*, Chapter 18, “Preventive and Screening Services”, Section 60.1 “Colorectal Cancer Screening; Payment”) contains additional information about colorectal cancer screening. CR 5127 is the official instruction issued to your Medicare carrier or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5127 may be found on the CMS web site at:

http://www.cms.hhs.gov/Transmittals/downloads/R1004CP.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

## Disclosure Desk Reference for Provider Contact Centers

*Reference: Trans. 16, CR #5089, Pub. 100-09, Medlearn Matters Number: MM5089*

***Provider Types Affected***

All physicians, providers, and suppliers billing Medicare

***Impact to You***

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

***What You Need to Know***

CR5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

***What You Need to Do***

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

***Background***

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

**Telephone Inquiries**

***Provider Authentication***

**CSR Telephone Inquiries** - Through May 22, 2007, Customer Service Representatives (CSR) will authenticate providers using provider number and provider name.

**Interactive Voice Response (IVR) Telephone Inquiries** - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

**Note:** See “Final Note” below to learn more about provider authentication after May 22, 2007.

**Written Inquiries**

***Provider Authentication***

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

**Note:** See “Final Note” below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), will be authenticated the same as written inquiries,(explained above) using provider name and the provider number.

**Insufficient or Inaccurate Requests**

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

***Beneficiary Authentication***

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1. Last name;
2. First name or initial;
3. Health Insurance Claim Number; and
4. Either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) or date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR5089 is available at http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf on the CMS web site.

***Special Instances***

Below are three special instances that you should know about.

**Overlapping Claims**

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

**Pending Claims**

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

**Deceased Beneficiaries**

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

**Final note:** More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI.

***Additional Information***

You can find more information about Provider Contact Center guidelines concerning authentication by going on the CMS web site to:

http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare Administrative Contractor (DME MAC), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found on the CMS web site at:

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

## Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure Coding System (HCPCS) Codes Applicable to Positron Emission Tomography (PET) Scan Services for Carriers

*Reference: Trans. 923, CR #5054, Pub. 100-04, Medlearn Matters Number: MM5054*

***Provider Types Affected***

Physicians and non-physician practitioners who bill Medicare carriers for PET scan services provided to Medicare beneficiaries.

***Background***

This article is based on CR5054, which updates Publication 100-04, The *Medicare Claims Processing Manual*, Chapter 13, Section 60.3.2 (Tracer Codes Required for PET Scans) to include two new HCPCS codes for radiopharmaceutical diagnosis imaging agents (tracers) applicable to PET scan services.

A prior Change Request, CR4270, Transmittal 822, released on February 1, 2006, addressed manual updates for Medicare fiscal intermediaries (FIs), but did not update the manual for carriers.

***Key Points***

- Effective for claims dates of service on or after January 1, 2006:
    - Ø **A9555** (Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium RB-82, Diagnostic, Per study dose, Up To 60 Millicuries) replaces Q3000; and
    - Ø **A9552** (Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, per study dose, Up to 45 Millicuries) replaces C1775.
- Effective for dates of service on or after January 1, 2006:
    - Ø HCPCS codes Q3000 and C1775 are deleted.
- A9555 is a Tracer code applicable to CPT 78491 and 78492.

***Additional Information***

**Note:** For claims with dates of service prior to January 1, 2006, OPPS hospitals report **C1775** and other providers billing fiscal intermediaries report **A4641** for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F1.

For claims with dates of service January 1, 2006, and later, providers billing fiscal intermediaries report **A9552** for radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18 in place of C1775 and A4641.

The Medicare Learning Network (MLN) article addressing the updated codes for FIs, MM4270, "Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure Coding System (HCPCS) Codes Applicable to Positron Emission Tomography (PET) Scan Services," can be found on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4270.pdf

CR5054, the official instruction issued to your carrier regarding changes mentioned in this article, may be found by going on the CMS web site to:

http://www.cms.hhs.gov/Transmittals/downloads/R923CP.pdf

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

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

## Clarification Regarding Effective Dates for Carrier Claim Adjustments: Denied Replacement Defibrillator Claims Lacking a QR Modifier

*Reference: Trans. 971, CR #5104, Pub. 100-04, Medlearn Matters Number: MM5104*

***Provider Types Affected***

Providers who bill carriers for Automatic Implantable Cardiac Defibrillator (ICD) services rendered to Medicare beneficiaries

***Impact to You***

If you have a claim for a replacement ICD that was denied solely because it lacked a QR modifier, you may request an adjustment for that claim for any date of service for which the replacement ICD was otherwise covered.

***What You Need to Know***

CR5104 clarifies CR4273 to establish that your carrier will consider any payable date of service when you seek an adjustment of a replacement ICD claim previously denied solely because it did not contain a QR modifier.

***What You Need to Do***

Make sure that your billing staff are aware that they can seek an adjustment for your replacement ICD claim denied due to lack of the QR modifier for any date of service for which the claim would otherwise have been payable.

***Background***

CR3604 (Transmittal 497), effective January 27, 2005, gave CMS carriers instructions on how to process Automatic Implantable Cardiac Defibrillator (ICD) claims for services provided under expanded coverage for new indications. One of these instructions was the requirement that the patient be enrolled in a data collection system.

Such patient enrollment is noted on the claim by the QR modifier, which identifies services being covered under a clinical study, and is required as a condition for payment on claims for ICD services rendered as:

- Part of the new indications (effective on January 27, 2005); or
- For any other ICD services rendered as a primary prevention of cardiac arrest (i.e., no history of induced or spontaneous arrhythmias).

To identify these instances, CMS systems maintainers created an edit to check the diagnosis code on the claim. If the diagnosis code was not a secondary prevention diagnosis code, then the QR modifier was required in order to cover the services.

Carriers turned on this edit, effective April 1, 2005. In order to ensure that the QR modifier was being applied to the extent possible to claims for ICD services rendered for the primary prevention of cardiac arrest, carriers were instructed to turn on the original edit such that claims with dates of service prior to April 1, 2005, would also be checked for this modifier as appropriate.

**Note:** When any of the secondary prevention diagnosis codes appear on an ICD claim, the QR modifier is not required. However, you can append the QR modifier for secondary prevention diagnoses when it is appropriate, i.e., when the data is submitted to a data collection registry.

After CR3604's publication, CMS became aware of additional possible diagnoses which show neither primary nor secondary prevention of cardiac arrest, for example when the ICD is replaced, due to ICD recall or device complication (such as the end of battery-life).

Since claims such as these should not be denied because they lack a QR modifier, on January 27, 2006, CMS issued CR4273 (Transmittal 819). CR4273 added two new ICD-9-CM diagnosis codes to the list of those that do not require a QR modifier and which do not, by themselves, represent a condition where primary or secondary prevention can be ascertained:

- **996.04**, Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator; and
- **V53.32**, Fitting and adjustment of other device, automatic implantable cardiac defibrillator.

To ensure that replacement ICD claims are not erroneously denied for a lack of QR modifier, the new edit accompanying CR4273 affects claims with dates of service on and after April 1, 2005. However, because the original carrier edit considered all dates of services as it checked for a QR modifier, including dates prior to April 1, 2005, it is possible that there will be replacement ICD claims erroneously denied with dates of service prior to April 1, 2005.

For this reason, when this issue is brought to their attention, Medicare carriers are to consider for possible adjustment all payable dates of service for replacement ICD claims when these claims have been denied solely for the lack of a QR modifier.

CR5104, from which this article is taken, makes this clarification and instructs carriers to inform you that you may have had claims for replacement ICDs erroneously denied for lack of a QR modifier and requiring such an adjustment.

Be aware, however, that the carriers do not have to search their files to retroactively pay claims, nor does this instruction apply to claims submitted to fiscal intermediaries (FIs), who implemented the original and revised edits according to dates of service.

***Additional Information***

You can find more information about the effective dates for carrier claim adjustments for replacement ICD claims denied because they lacked a QR modifier by going to CR5104, which is available on the CMS web site at:

http://www.cms.hhs.gov/Transmittals/downloads/R971CP.pdf

Additionally, more information about ICD claims may be found in MLN Matters articles MM3604 and MM4273, which you can find on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3604.pdf and
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4273.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.zip

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## Medicare Coverage of Abortion Services

*Reference: OK – TRB 072506*

Abortions are only covered under the Medicare program for the following instances:

- The pregnancy is a result of an act of rape or incest; or
- The woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Beginning July 1, 1999, providers should bill for abortion services that meet the criteria listed above with a modifier "G7". Modifier G7 is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physicians as life threatening." The G7 modifier is effective for dates of service on or after October 1, 1998.

Use modifier G7 with the following CPT codes in order for these abortion services to be considered:

| 59840 | 59852 | 59866 |
|---|---|---|
| 59841 | 59855 | 01964 |
| 59850 | 59856 | 01965 |
| 59851 | 59857 | 01966 |

When you bill one of these codes with modifier G7, you are certifying that the abortion services were medically necessary for one of the above situations. Remember that you may be subject to post-pay review.

# Medicare Part B versus Part D Drug Coverage Determinations

*Reference: Medlearn Matters Number: SE0652*

### *Provider Types Affected*

Physicians, pharmacists, providers, health care professionals, suppliers, and their staff

### *Impact on Providers*

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist physicians, providers, other prescribers and pharmacists to understand the CMS' recommended approach to simplifying and expediting the coverage determination process for Medicare Part B versus Part D.

Affected physicians, pharmacists, providers, and their staff may also wish to review *MLN Matters* article number SE0570, which provides a good summary of Medicare's drug coverage under Parts A, B, and D of Medicare. That article is available on the CMS web site at:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf

### *Background*

**Part B — Medical Insurance**

Medicare Part B covers drugs that are:

- Not usually self-administered; and
- Furnished and administered as part of a physician service.

Medicare Part B covers other selected drugs, such as the following:

- Drugs requiring administration via a piece of covered durable medical equipment (DME), such as a nebulizer or infusion pump in the home (because the law specifies "in the home" this coverage is generally not available in nursing facilities);
- Immunosuppressive drugs for people who had a Medicare covered transplant;
- Hemophilia clotting factors;
- Antigens;
- Intravenous immune globulin provided in the home;
- Certain oral anti-cancer and oral anti-emetic drugs;
- Erythropoietin for people with end stage renal disease (ESRD);
- Certain vaccines [Influenza, Pneumococcal, and (for intermediate- to high-risk individuals) Hepatitis B]; and
- Parenteral nutrition for people with a permanent dysfunction of their digestive tract.

Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision. For more information on local coverage determinations, go to http://www.cms.hhs.gov/coverage on the CMS web site.

**Part D — Prescription Drug Insurance**

Part D-covered drugs are defined as:

- Drugs available only by prescription, approved by the FDA, and used for a medically accepted indication which are not covered under part B (or Part A)

Certain drugs or classes of drugs (or their medical uses) are excluded by law from Part D coverage. These exclusions include the following:

- Benzodiazepines;
- Barbiturates;
- Drugs for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or for hair growth;

- Drugs used for symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products;
- Non-prescription drugs; and
- Drugs for which the manufacturer seeks to require as a condition of purchase that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee.
- Drugs for the treatment of sexual or erectile dysfunction (beginning in 2007 for Medicare Part D beneficiaries)

For more detailed information about Part B drugs and Part D coverage, please refer MLN Matters article SE0570 or to the detailed report on the CMS web site at:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf

This report provides excellent detail on the overall issue of Part B and Part D drugs.

**Recommended Process to Expedite Part B versus Part D Coverage Determinations**

Plans may rely on physician information included with the prescription, such as diagnosis information (e.g., to determine if the prescription is related to a Medicare covered transplant) or location of administration (e.g., to determine if the prescription is being dispensed for a beneficiary in a nursing home) to the same extent they rely on similar information acquired through documentation from physicians on prior authorization forms. Assuming the indication on the script is sufficient to make the coverage determination, there is no need in such cases to require additional information to be obtained from the physician.

To the extent that the plan requires their contracted pharmacies to report the information provided on the prescription to assist in the determination of Part B versus Part D coverage, the plan may rely on the pharmacist's report of appropriate information to make the coverage determination under Part D. For example, for cases in which prednisone is prescribed for a condition other than immunosuppression secondary to a Medicare-covered transplant, and this is indicated on the prescription, a plan may authorize the pharmacy to dispense the drug under Part D without seeking further information from the prescribing physician.

PDPs are prohibited from paying for drugs that are covered under Part B. Certain drugs such as prednisone are covered under Part B when they are used to prevent organ rejection for a patient who has had a Medicare covered transplant. When a plan gets a prescription for prednisone, they must have a process by which they can verify that the prednisone is being used for a disease which would not trigger Part B coverage. Initially the plans instituted cumbersome prior authorizations procedures which required that the prescriber fill out a prior authorization form and send the form to the plan. In order to simplify the process CMS has instructed the plans that if a prescription is written for a B/D drug and the prescription has written on it the words "Part D" and a part D diagnosis such as "contact dermatitis" the prescription should be filled.

CMS is not requiring physicians to fill out prescriptions in the manner described below; instead, it is suggested as a way to save time and bypass what may be a burdensome process of completing a prior authorization form and faxing it back.

**For example**, prednisone used for immunosuppression following Medicare covered transplants or methotrexate used for cancer would be Part B drugs for these diagnoses, but they would be *Part D* drugs if they were used to treat rheumatoid arthritis.

Using the CMS guidance outlined above, if prednisone is prescribed for rheumatoid arthritis:

- The Diagnosis is "Rheumatoid Arthritis;"
- The Statement of Status is "for Part D."

The information recommended by CMS for inclusion on the written prescription for prednisone prescribed for Rheumatoid Arthritis is "*Rheumatoid Arthritis for Part D*.

**Note:** This clarification should not be construed to indicate that a Part D plan may not impose prior authorization or other procedures to ensure appropriate coverage under the Medicare drug benefit.

The Part D Plan is ultimately responsible for making the Part D coverage determination. However, CMS believes that the Part D plan will have met appropriate due diligence standards without further contacting a physician if:

- Necessary and sufficient information is provided on the prescription; and

- The contracted pharmacy is able to communicate this information to the plan in order to make the coverage determination.

CMS is preparing additional guidance to assist plans, pharmacies, and physicians in operationalizing these Part B versus Part D coverage determinations.

This Special Edition information does not supersede any existing guidance concerning documentation for Part B prescriptions.

***Additional Information***

For more detailed information on Part B versus Part D coverage, see the following CMS web sites:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf

http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/DueDiligenceQA_03.24.06.pdf

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf

## *Comprehensive Error Rate Testing (CERT)*

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

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

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

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

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

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

## Medicare Part B Electronic Remittance Advice (835) File

*Reference: AR – KDA 080106*

Beginning July 11, 2006, electronic submitters who receive Medicare Part B electronic remittance advices (835's) in the ANSI 4010A1 format began receiving an additional electronic remittance advice in their electronic mailbox on the NetX Gateway system. The additional electronic remittance advice will have an MRP extension at the end of the filename and will be named MREP File. The MREP File contains the same information as the other electronic remittance advice (835) that electronic submitters have always received on the NetX Gateway. Electronic submitters will receive both electronic remittance advices.

The MREP remittance advice file is for those electronic submitters who have taken advantage of using the free MREP software. The MREP software converts the ANSI 4010A1 electronic remittance advice into a printable readable remittance advice.

The MREP File can be downloaded by direct electronic submitters, billing agents and clearinghouses. Direct electronic submitters who download their electronic remittance advice and are utilizing the MREP software can download the MREP File or the 835 Remittance file to import into the MREP software. It is not necessary to download both files. Billing agents and clearinghouses who download electronic remittance advices on behalf of providers can download the MREP File or the 835 Remittance file. It is recommended that billing agents and clearinghouses that do not have the ability to give providers a compliant 835 transaction (ISA-IEA) or cannot provide a paper remittance advice to their providers download the MREP File.

Please call EDI Services at (866) 582-3247 or (501) 378-2419 if you have any questions or wish to take advantage of the free MREP software.

## New Site for Medicare Provider Service Toll Free Numbers

*Reference: Medlearn Matters Number: SE0655*

### *Provider Types Affected*

All Medicare physicians, providers, and suppliers

### *Impact on Providers*

This article is mainly for informational purposes and discusses a new and more convenient web address and site that houses toll-free numbers that physicians, providers, and suppliers can use to contact their Medicare contractor (carriers, including durable medical equipment (DME) regional carriers and DME Medicare administrative contractors (DME MACs), and fiscal intermediaries, including regional home health intermediaries (RHHIs).

### *Background*

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce to all Medicare physicians, providers, and suppliers a new and improved web site for accessing Medicare Contractor Provider Call Center toll-free number information. The new site is located on the CMS web site at:

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

This change is a result of replacing the previous "Provider Call Center Toll-Free Numbers Directory" (with map) document with an Excel® file that contains all of the information previously available plus many improvements.

The original document proved difficult to update and download while keeping the functionality of the map intact. The new Excel's smaller file size allows for a significantly faster download, and the improved functionality, provided by the pull down menus, makes more targeted contact information available while filtering the displays appearing on the screen.

Additionally, a "Coverage Area" column has been added to the original four columns of information (i.e., State Served, Call Center, Program, and Toll-Free Number) and each column has a menu allowing users to filter the information displayed on the screen. Selecting the menus to "ALL" resets the spreadsheet to display all available information.

Many of the existing MLN Matters articles contain links to the previous map document, which was http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf on the CMS web site. As you can see, the new address is almost identical, except for the last three characters, "*pdf*," which are now "*zip*."

Please be aware that articles already housed on the MLN Matters pages will not be updated with the new link, except where such articles are revised in the future for other reasons. However, those providers who have been using the map document directory should already know where to find it within the CMS website and should, therefore, be able to locate the new document.

The directory is also prominent on all MLN pages and should be easy to find. In fact, now might be a good time to bookmark the new address or add it to your "Favorites" list:

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

The new spreadsheet directory will be updated approximately once every three months—more often if necessary.

As previously mentioned, you can access the new file from all major MLN web pages, including the main section pages at:

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

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

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

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

The new file can be downloaded directly from the CMS web site at:

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

CMS hopes you find this new site to be useful and we invite your comments and feedback on this and other Medicare Learning Network web-based products. You can provide such feedback by going on the CMS web site to:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/site_fdbck.php

## Cardiovascular System

*Reference: CR# 5048; Trans. 979, Pub. 100-04*

**Echocardiography Contrast Agents**

Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code A9700 (Supply of Injectable Contrast Material for Use in Echocardiography, per study). The type of service code is 9. This code will be carrier-priced.

**Electronic Analyses of Implantable Cardioverter-defibrillators and Pacemakers**

The CPT codes 93731, 93734, 93741 and 93743 are used to report electronic analyses of single or dual chamber pacemakers and single or dual chamber implantable cardioverter-defibrillators. In the office, a physician uses a device called a programmer to obtain information about the status and performance of the device and to evaluate the patient's cardiac rhythm and response to the implanted device.

Advances in information technology now enable physicians to evaluate patients with implanted cardiac devices without requiring the patient to be present in the physician's office. Using a manufacturer's specific monitor/transmitter, a patient can send complete device data and specific cardiac data to a distant receiving station or secure Internet server. The electronic analysis of cardiac device data that is remotely obtained provides immediate and long-term data on the device and clinical data on the patient's cardiac functioning equivalent to that obtained during an in-office evaluation. Physicians should report the electronic analysis of an implanted cardiac device using remotely obtained data as described above with CPT code 93731, 93734, 93741 or 93743, depending on the type of cardiac device implanted in the patient.

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## Boniva (Ibandronate)

*Reference: LA – DJL 081006*

Pinnacle Medicare Services recently received a question about the new drug, Boniva, coverage by Medicare Part B and its allowance information.

On May 9, 2006, intravenous Boniva (ibandronate) treatment was approved by the CMDs for Arkansas, Louisiana, Missouri, New Mexico, Oklahoma and Rhode Island for patients with postmenopausal osteoporosis. The primary ICD-9 code that should be used is 733.01 with E943.8 as a secondary code. To meet medical necessity, the documentation should clearly support that the patient was unable to tolerate the oral version of the drug.

Since Boniva does not have a HCPCS code assigned to it at this time, providers should utilize miscellaneous drug codes J3490 or J3590. Pricing information can be found on our state web sites under the Provider Information area then go to Publications and choose Fee Schedules. Under Fee Schedules proceed to the Drug Average Sales Price Fee Schedule. Allowance for Boniva would be calculated according to **Note 2 (see below)**:

**Payment Allowance Limits for Medicare Part B Drugs**
**Effective July 1, 2006 through September 30, 2006**

- **Note 1:** Payment allowance limits subject to the ASP methodology are based on 1Q06 ASP data.
- **Note 2:** The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor processing the claim.
- Click the following link to view the Payment Allowance Limits for Medicare Part B Not Otherwise Classified (NOC) Drugs.

## Axial Decompression Therapy Systems

*Reference: MO - LSB 081406*

Axial Decompression Therapy or Vertebral Axial Decompression is being utilized by various medical professionals for symptomatic pain relief associated with distinct disc problems including herniated or bulging discs, degenerative disc disease, posterior facet syndrome, sciatica, spinal stenosis, recurrent pain from a "failed back surgery", and acute and chronic back pain. The treatment regimen consists of 20-25 treatments lasting approximately 30-45 minutes each which purportedly stretches the spine and decompresses the discs, thus reducing disc pressures and relieving pressure on "pinched nerves". Some of the manufacturers claim that relief is obtained by improving the flow of nutrients into the disc and re-hydrating dried out discs.

The *Medicare National Coverage Determinations Manual, Publication 100-03*, Chapter 1, Part 2, Section 160.16 entitled *Vertebral Axial Decompression (VAX-D)* states, "there is insufficient scientific evidence to support the benefits of this technique. Therefore, VAX-D is not covered by Medicare." Because this NCD specifically refers to a treatment which "combines pelvic and/or cervical traction connected to a special table that permits the traction application", any similar device would fall under this category of a non-covered benefit.

Since VAX-D went on the market, numerous similar systems have been developed. These devices are approved by the FDA as predicate Class II devices. Pinnacle Medicare Services is including these devices as non-covered services, based on the above National Coverage Determination. These include such devices as DRX-9000™, the DRS System™, the Spina System™, the Lordex® Decompression Unit, the SpineMED™ Decompression Table, as well as any comparable devices that might be developed or are not named above providing (IDD) Therapy®.

The following CPT® codes should **not** be used to bill for services when providing axial decompression therapy:

| | |
|---|---|
| S9090 | Vertebral axial decompression, per session |
| 64722 | Decompression; unspecified nerve(s) (specify) |
| 97012 | Traction, mechanical |
| 97110 | Therapeutic exercise |
| 97112 | Neuromuscular re-education |
| 97140 | Manual therapy techniques |
| 97530 | Therapeutic activities |
| 90901 | Biofeedback training by any modality |
| 97039 | Unlisted modality |

If you provide this treatment to your patients and they request that you bill Medicare or you are billing for an insurance denial for secondary insurance, please note that it is a **non-covered service**. You should provide your patient with a Notice of Exclusion of Medicare Benefits (NEMB), bill procedure code 97799 with the following description of the service: Intervertebral Disc Decompression, Axial Decompression, or the name of the device utilized. You must place a GY modifier on the claim indicating that the NEMB was signed by the beneficiary **prior** to provision of service and that this is maintained in their medical record.

**References:**


- *Medicare National Coverage Determinations Manual, Publication 100-03*, Chapter 1, Part 2, Section 160.16.
- *Current Procedural Terminology* ©2005 American Medical Association. All Rights Reserved. CPT® is a trademark of the American Medical Association.
- DRX 9000™ is a trademark of Axiom Worldwide, Inc., Tampa, Florida.
- The DRS System™ is a trademark of Professional Distribution Systems, Inc., Boca Raton, Florida.
- The Spina System™ and IDD Therapy® are trademarks of North American Medical Corporation, Atlanta, Georgia.
- The Lordex® Decompression Unit is a trademark of Lordex, Inc., Houston, Texas.
- The SpineMED™ Decompression Table is a trademark of Cert Health Sciences, LLC, Newtown, Connecticut.
- The article entitled *Welcome to Vax-D The Non-Surgical Solution to Back Pain* may be found at www.vax-d.com and provides a comprehensive guide to this product.

- The article entitled *The NEW Treatment for Low Back Pain…DRX9000* may be found at www.healthworksimc.c/DRX9000.htm and describes this product.
- The article entitled *DRS System* may be found at www.correctivecare.com/drs.html and describes this product.
- The website link to a description of the Alpha-Spina System is www.adagen.com/physicians/products_alpha.htm
- Information on the Lordex® Decompression Unit may be found at www.lordex.com
- Information on SpineMED™ may be found at www.certhealthsciences.com/index.html
- Information on IDD Therapy® may be found at www.iddtherapy.com
- Aetna Clinical Policy Bulletin Number 0180 *Vertebral Axial Decompression Therapy*, April 11, 2006 may be found at www.aetna.com/cpb/data/CPBA0180.html
- An article entitled *Coverage limitations for spinal therapies (VAX-D, DRS system, DRX9000, MEDX, Spina System)* may be found at www.medicarenhic.com/cal_prov/articles/spinaltherapies_1105.htm
- An article entitled, *Be Wary of Vax-D Therapy* by Stephen Barrett, M.D. may be found at www.chirobase.org/06DD/vaxd/vaxd.html

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## UPDATE - CMS 1500 Claim Form Revisions

*Reference: AR – GPH 081706*

**The timeline for the CMS-1500 for have changed based on CR 5060.**

**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 ***January 1, 2007***, but will not be mandated for use until February 1, 2007.

The following is the Form CMS-1500 form timeline:

- ***January 2, 2007***: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised Form CMS-1500 (08/05).
- ***January 2, 2007– March 30, 2007***: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- ***April 2, 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 on page 6 of the April 2006 *Medicare Providers' Newsletter*. The CMS Change Request is 4293 and 5060. The change in the CMS-1500 is being coordinated by the National Uniform Claims Committee (NUCC), www.nucc.org.

## Travel Allowance Fees for Collection of Specimen

*Reference: LA - RSH 081806; Pub. 100-4, Ch. 16 and Sec. 60.2*

***This is a clarification of instructions published on page 21 in the April 1999 Medicare Providers' News.***

In addition to a specimen collection fee allowed under §60.1, Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under §1833(h)(3) of the Act and payment is made based on the clinical laboratory fee schedule. The travel allowance is intended to cover the estimated travel costs of collecting a specimen and to reflect the technician's salary and travel costs.

The additional allowance can be made only where a specimen collection fee is also payable, i.e., no travel allowance is made where the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel. The travel allowance may not be paid to a physician unless the trip to the home or to the nursing home was solely for the purpose of drawing a specimen. Otherwise travel costs are considered to be associated with the other purposes of the trip.

The travel allowance is not distributed by CMS. Instead, the carrier must calculate the travel allowance for each claim using the following rules for the particular Code. The following HCPCS codes are used for travel allowances:

**Per Mile Travel Allowance (P9603)**

The minimum "per mile travel allowance" is 75 cents. The per mile travel allowance is to be used in situations where the average trip to patients' homes is **longer than 20 miles** round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. - one way, in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home bound patient; prorated miles actually traveled (carrier allowance on per mile basis).

The units entered in item 24g of the CMS-1500 claim form should be the pro-rated miles for each patient with a blood draw for a given day.

**Example 1:** In CY 2000, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $45.00 (60 miles x .75 cents a mile), plus the specimen collection fee of $3.00.

**Example 2:** In CY 2000, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $30.00 (40 x .75), plus the specimen collection fee of $3.00.

- Pro-rate the miles, if applicable (total miles for the day divided by the total number of patients that have specimen collected outside the lab that day)
- The lab must bill code for the specimen collection fee on the same claim
- **The modifier LR is not appropriate to bill since the lab is billing for total miles**

**Flat Rate (P9604)**

The CMS will pay a minimum of $7.50 **one way** flat rate travel allowance. The flat rate travel allowance is to be used in areas where average trips are **less than 20 miles** round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The laboratory does the pro-ration when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be paid for each patient encounter.

**The claimant identifies round trip travel by use of the LR modifier.**

**Example 3:** A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $7.50 for a total trip reimbursement of $15.00, plus the specimen collection fee.

**Example 4:** A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $7.50 = $45.00). Each of the claims submitted would be for $9.00 ($45.00 /5 = $9.00).

Since one of the patients is non-Medicare, four claims would be submitted for $9.00 each, plus the specimen collection fee for each.

**Example 5:** A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $7.50 = $15.00) and then divided by five (1/5 of $15.00 = $3.00). Since one of the patients is non-Medicare, four claims would be submitted for $3.00 each, plus the specimen collection fee.

- The lab must bill a code for the specimen collection fee on the same claim
- Pro-rate the charge in item 24f (if applicable)
- **The modifier LR should be used with HCPCS code P9604 to identify round trip**

# *Health Professional Shortage Area (HPSA)*

## 2007 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

*Reference: Trans. 1021, CR #5237, Pub. 100-04, Medlearn Matters Number: MM5237*

***Provider Types Affected***

Physicians and providers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for services provided in HPSAs

***Impact on Providers***

This article is based on Change Request (CR) 5237, which alerts affected physicians, providers, carriers, and FIs that the new HPSA bonus payment information for 2007 will soon be available.

***Background***

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually.

CR5237 instructs carriers and FIs to use the new HPSA bonus payment file for the automated bonus payment for claims with dates of service on or after January 1, 2007, through December 31, 2007.

In addition, CMS is notifying affected physicians/providers that it will post the new HPSA information to the CMS web site on or about October 1, 2006.

***Implementation***

The implementation date for the instruction is January 2, 2007.

***Additional Information***

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

http://www.cms.hhs.gov/Transmittals/downloads/R1021CP.pdf

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.zip

## Indian Health Services (IHS) – Clarifications and Additions to Chapter 19

*Reference: Trans. 1027, CR #5230, Pub. 100-04*

Change Request (CR) 5230 includes new sections and clarifications to previously released sections of Chapter 19, Indian Health Services (IHS) in the *Medicare Claims Processing Manual*. This update to Chapter 19 includes documentation pertinent to the fiscal intermediary (FI), carrier and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for IHS and should be reviewed in its entirety. Documentation for all CMS approved transmittals issued prior to this CR is included in this revision.

There are no policy changes or system changes associated with this revision to Chapter 19. All policy and system changes were implemented based upon the implementation dates associated with the specific CRs previously released.

To view the complete CR 5230, please visit:

http://www.cms.hhs.gov/Transmittals/2006Trans/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=5&sortOrder=ascending&itemID=CMS1185660

## Medicare Interactive Voice Response System

*Reference: LA – VC 072806*

In December of 2005, we implemented a new Interactive Voice Response or Voice Recognition (IVR) system. This new IVR allows you to obtain information through speech interaction rather than touch tone. Some of the information available to you through our new IVR is claims status, eligibility records, and reimbursement checks information. Additionally the IVR is available in English and Spanish. When you call into our IVR you will be greeted by a pleasant automated voice which will instruct you on what information to speak to obtain data from our IVR. The below information will provide you with an overview of the new IVR options and provide you with additional facts that will help you to expedite your call.

To reach the Interactive Voice Recognition System, providers should call the following toll free number:

| | |
|---|---|
| **Arkansas Part B** | **877-908-8434** |
| **Louisiana Part B** | **877-567-7204** |
| **Missouri Part B** | **866-539-5599** |
| **New Mexico Part B** | **877-567-9230** |
| **Oklahoma Part B** | **877-567-9230** |
| **Rhode Island Part B** | **877-846-2820** |

You will begin by hearing a female voice speaking **"Hi thanks for calling your Medicare** Part **(A or B) Service System"**. You will then be given the option to obtain data in Spanish. The system automatically defaults to English if you do not choose the Spanish option. After that the system will ask you to hold while it accesses Medicare's computers. You will hear a short moment of music and then you will be prompted to speak your Provider Number. *You must speak your number; touch tone is not available at this time.*

To use the IVR system, you must have a valid Provider Number. Always use your Group Provider Number if you are associated with a group practice. To enter the number, you simply speak the number naturally.

Once your Provider number has been validated you will be given the following options to choose from the **Main Menu**: ***Claims Status, Eligibility Information, Reimbursement Checks Status and Other Options.*** When selecting **Eligibility** or **Claims** you will be ask for your patient's Medicare number, please have that information available.

**CLAIMS OPTION**

- You may say **Claim** for the status of a claim or claims.
- You will then be asked for the Medicare number and date of service in question.
- Once your information has been accepted. The IVR will speak back the total amount submitted, deductible applied, payment amount, check number, and allowed amount.
- At this point you can request more detail on the claim by speaking **More Detail**. This feature will give you the date of service, medical procedure code, modifier, billed amount and approved amount or denial message.
- After this you may say **Repeat** to repeat the claim information,
- Or you can say **Another Claim** to receive data on another claim on same patient, a claim on a different patient, or to switch provider numbers to search for claims under another provider number.
- Or speak **I'm Done** if you are finished.

***This information can be accessed from 6:00 a.m. to 6:00 p.m. Monday through Friday.***

**ELIGIBILITY OPTION**

You may say **Eligibility** to receive information on Part A and Part B entitlement, deductible information, and Medicare primary/secondary data, Health Maintenance Organizations on file, Home Health and Hospice information. *When calling about eligibility you must be able to validate the following information about the Beneficiary:*

***Beneficiary's first and last name***

***Beneficiary's Health Insurance Claim (HIC) number***
***Beneficiary's gender and Date of Birth***

***This information can be accessed from 6:00 a.m. to 6:00 p.m. Monday through Friday.***

**CHECKS OPTION**

- You may say **Checks** to get information on checks or a specific check. You may search by specific check number, a date or range of dates, or status.
- You may say **Number** to receive information on a specific check number. You must have the check number for this search.
- You may say **Date** to get information on a specific date or range of dates. You do not need the check number.
- You may say **Status** to do a search by ***cleared status, outstanding status, stopped status or voided status.***

***This information can be accessed from 6:00 a.m. to 6:00 p.m. Monday through Friday.***

**OTHER OPTION**

You may say **Other Options** to receive information on Remittance Notice Copies, Customer Service Numbers, Appeals Rights and Seminars.

This information is available 24 hours.

- You may say **Remittance Notice** to learn how to obtain copies of your notice.
- You may say **Customer Service Number** to receive information on how to speak with a customer service representative.
- You may say **Appeals** to learn about the Medicare appeals process.
- You may say **Seminars** to learn more about Medicare seminars or workshops in your area.

Once you have obtained your information, you may say **Main Menu**, to bring you back to the Main Menu. You must have entered a valid provider number to receive this information.

**Helpful Hints**

- You must speak your information we are not programmed for touchtone at this time
- You will need to have your provider number and patient information ready when calling. The system will not accept the Tax ID number or the UPIN number.
- You cannot reach customer service through the IVR. You can get Customer Service Phone numbers and through the Main Menu's other options.
- Railroad Medicare Numbers have a prefix that begins with a letter. You will need to call Railroad Medicare at 877-288-7600.
- Give the complete Medicare number, using the 9 numeric digits including the suffix.
- When speaking an alpha character do not emphasis by speaking a descriptive word behind the character. (For Example "B as in Boat" or "A as in Apple"). This will confuse the IVR.
- Speak naturally when giving information.
- The IVR is sensitive to background noises and may interpret it as your response. The following situations will cause problems with your call: speaking to others in the office, laughing, coughing, sneezing and loud noises in the background.
- Please listen to the system prompts very carefully. These prompts will let the caller know what the system is expecting to hear from the caller. Once you are familiar with the prompts you can barge ahead.

***Our staff is working continuously to bring you improved and enhanced services through the new Interactive Voice Response System. We welcome your input and/or suggestions through our Contact Us section of your state web site.***

## CMS Awards First of 15 Contracts to Process and Pay Medicare Part A & B Claims

*Reference: CMS List-Serv Message 073106*

The Centers for Medicare & Medicaid Services (CMS) today announced the award of the first of 15 contracts for the combined handling in six states of both Part A and Part B Medicare claims. The winning contractor is Noridian Administrative Services, LLC, (NAS), headquartered in Fargo, N.D.

As the new Part A/Part B Medicare Administrative Contractor (A/B MAC), NAS will serve as the first point-of-contact for processing and paying fee-for-service claims from hospitals and other institutional providers, physicians, and other practitioners in Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming.

"The contract award is a major step to improved Medicare service for beneficiaries and providers, and significant cost savings from greater efficiency in managing the original fee-for-service Medicare program," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Noridian Administrative Services was selected through a full and open performance-based competition to administer the program as effectively and efficiently as possible."

The A/B MAC contract, which has a value of $28.9 million for the first year of performance, is the first of 15 to be awarded by 2011 to fulfill requirements of the contracting reform provisions of the Medicare Modernization Act of 2003. NAS will immediately begin implementation activities and will assume full responsibilities for the claims processing work in its six-state jurisdiction no later than March 2007.

For more information, see:

http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1919

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

*Reference: CR 4023; LA – FM 061606*

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

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

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

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

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

Arkansas Medicare Part B --------------- 00520

New Mexico Medicare Part B ----------- 00521

Oklahoma Medicare Part B -------------- 00522

Missouri Medicare Part B ----------------- 00523

Rhode Island Medicare Part B ---------- 00524

Louisiana Medicare Part B --------------- 00528

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

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

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

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

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

M368 2330D
M369 2330E
M370 2330F
M372 2330H

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

M371 2420C
M378 2310D

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## NPI: Get It. Share It. Use It.

*Reference: CMS List-Serv Message 072706*

As the industry transitions to NPI compliance, remember that there is no charge to get an NPI. Providers can apply online for their NPI, free of charge, by visiting https://nppes.cms.hhs.gov or by calling 1-800-465-3203 to request a paper application. The CMS NPI page, located at http://www.cms.hhs.gov/NationalProvIdentStand/, is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include legacy identifiers on their NPI applications, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. If providers have already applied for their NPI, CMS asks them to go back into the NPPES and update their information with their legacy identifiers. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

## Stage 2 Use and Editing of the National Provider Identifier (NPI)

*Reference: CR 4023B5; AR - LMB – 082106*

Stage 2 implementation of the National Provider Identifier (NPI) will begin on October 1, 2006 and will end on May 22, 2007. Submitters of X12 837, (including claims submitted via MCE software) and DDE claims should continue to submit the Medicare Part B 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.

Effective October 2, 2006 there will be 5 new Medicare Part B pre-pass edits that will be implemented. The Medicare Part B pre-pass edits will reject claims on the Batch Detail Control Listing (H99) report if certain criteria have not been met.

| EDIT | LOOP | EDIT LOGIC |
|---|---|---|
| M379 | 2010AA | The 2010AA TIN does not match the NPI number reported and the 2010AA or 2010AB REF01 of 1C is not present. |
| M380 | 2010AB | The 2010AB TIN does not match the NPI number reported and the 2010AA or 2010AB REF01 of 1C is not present. |
| M381 | 2310B | The 2310B TIN does not match the NPI number reported and the 2310B REF01 of 1C is not present. |
| M382 | 2420A | The 2420A TIN does not match the NPI number reported and the 2420A REF01 of 1C is not present. |
| M387 | 2010AA<br>2010AB | The 2010AA or 2010AB loop does not contain a REF01 of 1C and the 2010AA or 2010AB contains a value of XX in the NM108 and the REF02 and the 1000B NM109 values do not correspond. |

In addition to the 5 new Medicare Part B pre-pass edits, Medicare Part B will modify pre-pass edit M010. Pre-pass edit M010 will reject claims when the 2010AA/2010AB NM108 is not XX or a REF with a 1C qualifier is not present in the 2010AA/2010AB.

## End of Contingency for Electronic Remittance Advice (ERA)

*Reference: Medlearn Matters Number: SE0656; JSM 4109-06599*

***Provider Types Affected***

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

***Background***

The purpose of this Special Edition article is to clarify for providers the information issued by the Centers for Medicare & Medicaid (CMS) regarding the date to end the contingency plan for ERAs.

***Key Points***

Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice – transaction 835 version 004010A1 – to all electronic remittance advice receivers. In addition, CMS issued instructions in Change Request (CR) 5047 that required a one-time hold of Medicare payments for the period of September 22, 2006, to September 30, 2006, for claims that would have been paid during the last 9 business days of fiscal year 2006. See the *MLN Matters* article on CR5047 on the CMS web site at:

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

CMS has further instructed that on or after October 1, 2006:

- Any ERA for claims that would be held per CR5047 or for any other reason shall be created in the HIPAA compliant format.
- Any duplicate remittance advice per provider request shall be created in the HIPAA compliant, if electronic, or paper format.

Current figures indicate that 99% of all ERA receivers (providers and other entities that receive the ERA on behalf of providers) are receiving a HIPAA compliant ERA format and they are unaffected by the end of the contingency plan. The remaining **1% of legacy ERA receivers need to transition to a HIPAA compliant ERA format** between now and October 1, 2006. The following are the **options available** to you as a legacy ERA receiver:

- Start receiving HIPAA compliant ERAs beginning on October 1, 2006.
- Request to switch to Standard Paper Remittance (SPR) advice.
    - Ø If you are already receiving an SPR, and do not want to receive the HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier to stop sending any ERA.
    - Ø If providers are not currently receiving SPR, and do not wish to switch to HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier that you would like to start receiving SPR and not receive any ERA.

There are tools available to providers to view and print the remittance advice information using free Medicare software (PC Print for institutional providers and Medicare Remit Easy Print (MREP) for professional providers and suppliers). These free software packages are 835 version 004010A1 compatible and will not work with any legacy ERA. Both software packages have important advantages over the SPR. Both packages can also be used to generate a hard copy remittance to be sent for secondary/tertiary billing, and for accounts receivable reconciliation. See the additional information section of this article for MREP details.

***Additional Information***

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

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

Or, you can view Special Edition MLN Matters article SE0611 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf or a related MLN Matters article (MM4376) at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf on the CMS web site.

For more information about the MREP software and how to receive the HIPAA 835, please contact your FI, RHHI, carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf on the CMS web site. Those billing for Part A services can find the appropriate toll free number at http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartAEDIHelpline.pdf on the CMS web site.

## Outpatient Therapy – Additional DRA Mandated Service Edits

*Reference: Trans. 1019, CR #5253, Pub. 100-04*

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, and CORFs were required to report their full range of CORF services on the Form CMS-1450. These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.

**Timed and Untimed Codes**

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

**Example:** A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92506. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.

Providers billing to FIs and RHHIs should report Value Code 50, 51, or 52, the total number of physical therapy, occupational therapy, or speech–language pathology visits provided from start of care through the billing period. This item is visits, not service units. Value codes do not apply to claims sent to carriers.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using CPT codes and the appropriate number of 15 minute units of service.

**Example:** A beneficiary received occupational therapy (HCPCS "timed" code 97530 which is defined in 15 minute units) for a total of 60 minutes. The provider would then report revenue code 043X and 4 units.

**Counting Minutes for Timed Codes in 15 Minute Units**

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

**Units Number of Minutes**

1 unit: • 8 minutes through 22 minutes

2 units: • 23 minutes through 37 minutes

3 units: • 38 minutes through 52 minutes

4 units: • 53 minutes through 67 minutes

5 units: • 68 minutes through 82 minutes

6 units: • 83 minutes through 97 minutes

7 units: • 98 minutes through 112 minutes

8 units: • 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Publication 100-02, chapter 15, section 230.3B Treatment Notes indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

**Example 1:**

24 minutes of neuromuscular reeducation, code 97112,

23 minutes of therapeutic exercise, code 97110,

Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

**Example 2:**

20 minutes of neuromuscular reeducation (97112)

20 minutes therapeutic exercise (97110),

40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

**Example 3:**

33 minutes of therapeutic exercise (97110),

7 minutes of manual therapy (97140),

40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

**Example 4:**

18 minutes of therapeutic exercise (97110),

13 minutes of manual therapy (97140),

10 minutes of gait training (97116),

8 minutes of ultrasound (97035),

49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be

billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

**Example 5:**

7 minutes of neuromuscular reeducation (97112)

7 minutes therapeutic exercise (97110)

7 minutes manual therapy (97140)

21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

**Note:** The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes-- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.

**Specific Limits for HCPCS**

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

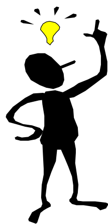
This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called “always therapy” must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

- The codes that are allowed one unit for “Allowed Units” in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.
- The codes allowed 0 units in the column for “Allowed Units”, may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).
- When physicians/NPPs bill “always therapy” codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an “always therapy” code unless the service is provided under a therapy plan of care. Therefore, NA stands for “Not Applicable” in the chart below.
- When a “sometimes therapy” code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

| HCPCS | Code Description and Claim Line Outlier/Edit Details | Timed or Untimed | PT Allowed units | OT Allowed units | SLP Allowed units | Physician/NPPN OT under Therapy POC |
|---|---|---|---|---|---|---|
| 92506 | Speech/hearing evaluation | Untimed | 0 | 0 | 1 | NA |
| 92597 | Oral speech device eval | Untimed | 0 | 1 | 1 | NA |
| 92607 | Ex for speech device rx, 1hr | Timed | 0 | 1 | 1 | NA |

| HCPCS | Code Description and Claim Line Outlier/Edit Details | Timed or Untimed | PT Allowed units | OT Allowed units | SLP Allowed units | Physician/NPPN OT under Therapy POC |
|---|---|---|---|---|---|---|
| 92611 | Motion fluroscopy/swallow | Untimed | 0 | 1 | 1 | 1 |
| 92612 | Endoscope swallow test (fees) | Untimed | 0 | 1 | 1 | 1 |
| 92614 | Laryngoscopic sensory test | Untimed | 0 | 1 | 1 | 1 |
| 92616 | Fees w/laryngeal sense test | Untimed | 0 | 1 | 1 | 1 |
| 95833 | Limb muscle testing, manual | Untimed | 1 | 1 | 0 | 1 |
| 95834 | Limb muscle testing, manual | Untimed | 1 | 1 | 0 | 1 |
| 96110 | Developmental test, lim | Untimed | 1 | 1 | 1 | 1 |
| 96111 | Developmental test, extend | Untimed | 1 | 1 | 1 | 1 |
| 97001 | PT evaluation | Untimed | 1 | 0 | 0 | NA |
| 97002 | PT re-evaluation | Untimed | 1 | 0 | 0 | NA |
| 97003 | OT evaluation | Untimed | 0 | 1 | 0 | NA |
| 97004 | OT re-evaluation | Untimed | 0 | 1 | 0 | NA |



# Medicare Web-Based Training

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

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

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

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

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

## Current Topics

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

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

For more information visit your Medicare Carrier's website:

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

## Pinnacle Medicare Services Seminar Registration

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

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

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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)*

**Seminars:**

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

_______ More frequent _______ Longer seminars _______ Specialty workshops

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

______________________________________________________________________________

______________________________________________________________________________

**Website:**

Have your ever visited our website? _______Yes _______No

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

Do you find the website easy to navigate? _______Yes _______No

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

____________________________________ (______)____________________________

Name Telephone Number

________________________________________________________________________

Street Address

________________________________________________________________________

City/State/Zip Code

# Arkansas Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts | | |
|---|---|---|---|
| Rural | Ashley | | |
| | | Portland/Wilmot SA | |
| | | | Banner Twp. |
| | | | Bayou Twp. |
| | | | Bearhouse Twp. |
| | | | Beech Creek Twp. |
| | | | De Bastrop Twp. |
| | | | Montrose Twp. |
| | | | Portland Twp. |
| | | | Prairie Twp. |
| | | | Union Twp. |
| | | | Wilmot Twp. |
| Rural | Boone | | |
| | | Marion | |
| | | | Sugar Loaf Twp. |
| Rural | Bradley | | |
| | | Hermitage | |
| | | | Eagle Twp. |
| | | | Marion Twp. |
| | | | Ouachita Twp. |
| | | | Palestine Twp. |
| | | | River Twp. |
| | | | Sumpter Twp. |
| | | | Washington Twp. |
| Rural | Calhoun | | |
| | | Calhoun | |
| Rural | Chicot | | |
| | | Desha/Chicot | |
| | | | Bowie Twp. |
| Rural | Cleveland | | |
| | | Cleveland | |
| Urban | Crawford | | |
| | | Mountainburg | |
| | | | Bidville Twp. |
| | | | Chester Twp. |
| | | | Locke Twp. |
| | | | Mountainburg Twp. |
| | | | Porter Twp. |
| | | | Upper Twp. |
| | | | Whitley Twp. |
| | | | Winfrey Twp. |
| Rural | Cross | | |
| | | Cross | |
| Rural | Dallas | | |
| | | Sparkman | |
| | | | Manchester Twp. |
| | | | Nix Twp. |
| | | | Owen Twp. |
| | | Carthage | |
| | | | Chester Twp. |
| | | | Smith Twp. |
| | | | Willow Twp. |
| | | Bearden | |
| | | | Holly Springs Twp. |
| Rural | Desha | | |
| | | Desha/Chicot | |
| | | | Desha |
| Urban | Faulkner | | |
| | | California | |
| | | | Benton Twp. |
| | | | California Twp. |
| | | | Enola Twp. |
| | | | Matthews Twp. |
| | | | Mount Vernon Twp. |
| | | | Mountain Twp. |
| | | | Walker Twp. |
| Rural | Franklin | | |
| | | Charleston SA | |
| | | | Barham Twp. |
| | | | Donald Twp. |
| | | | Grover Twp. |
| | | | Hurricane Twp. |
| | | | Middle Twp. |
| | | | Mill Creek Twp. |
| | | | Prairie Twp. |
| | | | Weaver Twp. |
| | | | Wittich Twp. |
| | | | Six Mile Twp. |
| Rural | Fulton | | |
| | | Mammoth Spring | |
| | | | Afton Twp. |
| | | | Mammoth Spring. Twp. |
| | | | Myatt Twp. |
| | | | Wilson Twp. |
| Rural | Grant | | |
| | | Grant | |
| Rural | Howard | | |
| | | Dierks | |
| | | | Blue Ridge Twp. |
| | | | Burg Twp. |
| | | | Clay Twp. |
| | | | Duckett Twp. |
| | | | Holly Creek Twp. |
| | | | Madison Twp. |
| | | | Mountain Twp. |
| | | | Muddy Fork Twp. |
| | | | Umpire Twp. |
| Urban | Jefferson | | |
| | | Redfield | |
| | | | Barraque Twp. |
| | | | Bolivar Twp. |
| | | | Jefferson Twp. |
| | | | Pastoria Twp. |

## *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.*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| | Altheimer |
| | C.T. 0001.02 |
| | C.T. 0001.85 |
| | C.T. 0007.00 |
| | North Pine Bluff |
| | C.T. 0005.02 |
| | C.T. 0006.00 |
| | C.T. 0006.99 |
| | Richland |
| | C.T. 0008.00 |
| Rural | Johnson |
| | Ozark |
| | Batson Twp. |
| | Dickerson Twp. |
| | Hill Twp. |
| | Low Gap Twp. |
| | Mulberry Twp. |
| Rural | Lafayette |
| | Lafayette |
| Rural | Lincoln |
| | Lincoln |
| Rural | Lonoke |
| | England |
| | Crooked Creek Twp. |
| | Fletcher Twp. |
| | Gum Woods Twp. |
| | Indian Bayou Twp. |
| | Lafayette Twp. |
| | Pettus Twp. |
| Rural | Madison |
| | Madison |
| Rural | Marion |
| | Marion |
| | Marion |
| Rural | Montgomery |
| | Montgomery Co |
| Rural | Nevada |
| | Nevada |
| Rural | Newton |
| | Newton |
| Rural | Quachita |
| | Stephens SA |
| | Jefferson Twp. |
| | Liberty Twp. |
| | Smackover Twp. |
| | Reader |
| | Behestian Twp. |
| | Red Hill Twp. |
| | Bearden |
| | Carroll Twp. |
| | Cleveland Twp. |
| | Freeo Twp. |
| | Union Twp. |
| | Valley Twp. |

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Perry |
| | Perry |
| Rural | Polk |
| | Grannis/Wickes |
| | Ozark Twp. |
| | White Twp. |
| Rural | Pope |
| | Hector |
| | Center Twp. |
| | Freeman Twp. |
| | Griffin Twp. |
| | Jackson Twp. |
| | Liberty Twp. |
| | Martin Twp. |
| | Phoenix Twp. |
| | Smyrna Twp. |
| Urban | Pulaski |
| | College Station |
| | C.T. 0002.00 |
| | C.T. 0004.00 |
| | C.T. 0005.00 |
| | C.T. 0040.01 |
| | C.T. 0040.03 |
| | C.T. 0040.05 |
| Rural | St. Francis |
| | St. Francis |
| Rural | Scott |
| | Scott |
| Rural | Searcy |
| | Searcy |
| Rural | Union |
| | Strong |
| | Harrison Twp. |
| | Lapile Twp. |
| Rural | Van Buren |
| | Van Buren |
| Urban | Washington |
| | West Washington |
| | District No. 10 Twp. |
| | District No. 11 Twp. |
| Rural | Yell |
| | Havana |
| | Bluffton Twp. |
| | Briggsville Twp. |
| | Crawford Twp. |
| | Dutch Creek Twp. |
| | Gravelly Hill Twp. |
| | Herring Twp. |
| | Ions Creek Twp. |
| | Richland Twp. |
| | Riley Twp. |
| | Waveland Twp. |

## Arkansas Mental Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Arkansas |
| | Pine Bluff C.A. |
| | Arkansas |
| Rural | Ashley |
| | Monticello C.A. |
| | Ashley |
| Rural | Baxter |
| | Mountain Home C.A. |
| | Baxter |
| Rural | Boone |
| | Mountain Home C.A |
| | Boone |
| Rural | Bradley |
| | Monticello C.A |
| | Bradley |
| Rural | Calhoun |
| | El Dorado C.A |
| | Calhoun |
| Rural | Carroll |
| | Carroll/Madison C.A |
| | Carroll |
| Rural | Chicot |
| | Monticello C.A |
| | Chicot |
| Rural | Clark |
| | Hot Springs C.A |
| | Clark |
| Rural | Clay |
| | Jonesboro C.A |
| | Clay |
| Rural | Cleburne |
| | Batesville C.A |
| | Cleburne |
| Rural | Cleveland |
| | Pine Bluff C.A |
| | Cleveland |
| Rural | Columbia |
| | El Dorado C.A |
| | Columbia |
| Rural | Conway |
| | Russellville C.A |
| | Conway |
| Rural | Craighead |
| | Jonesboro C.A |
| | Craighead |
| Urban | Crawford |
| | Fort Smith C.A |
| | Crawford |
| Rural | Crittenden |
| | Helena C.A |
| | Crittenden |

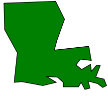
| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Cross |
| | Helena C.A |
| | Cross |
| Rural | Dallas |
| | El Dorado C.A |
| | Dallas |
| Rural | Desha |
| | Monticello C.A |
| | Desha |
| Rural | Drew |
| | Monticello C.A |
| | Drew |
| Rural | Faulkner |
| | Russellville C.A |
| | Faulkner |
| Urban | Franklin |
| | Fort Smith C.A |
| | Franklin |
| Rural | Fulton |
| | Batesville C.A |
| | Fulton |
| Rural | Garland |
| | Hot Springs C.A |
| | Garland |
| Rural | Grant |
| | Pine Bluff C.A |
| | Grant |
| Rural | Greene |
| | Jonesboro C.A |
| | Greene |
| Rural | Hempstead |
| | Texarkana C.A |
| | Hempstead |
| Rural | Hot Springs |
| | Hot Springs C.A |
| | Hot Springs |
| Rural | Howard |
| | Texarkana C.A |
| | Howard |
| Rural | Independence |
| | Batesville C.A |
| | Independence |
| Rural | Izard |
| | Batesville C.A |
| | Izard |
| Rural | Jackson |
| | Batesville C.A |
| | Jackson |
| Rural | Jefferson |
| | Pine Bluff C.A |
| | Jefferson |

## *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.*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Johnson<br>Russellville C.A<br>Johnson |
| Rural | Lafayette<br>Texarkana C.A<br>Lafayette |
| Rural | Lawrence<br>Jonesboro C.A<br>Lawrence |
| Rural | Lee<br>Helena C.A<br>Lee |
| Rural | Lincoln<br>Pine Bluff C.A<br>Lincoln |
| Rural | Little River<br>Texarkana C.A<br>Little River |
| Urban | Logan<br>Fort Smith C.A<br>Logan |
| Rural | Madison<br>Carroll/Madison C.A<br>Madison |
| Rural | Marion<br>Mountain Home C.A<br>Marion |
| Rural | Miller<br>Texarkana C.A<br>Miller |
| Rural | Mississippi<br>Jonesboro C.A<br>Mississippi |
| Rural | Monroe<br>Helena C.A<br>Monroe |
| Rural | Montgomery<br>Hot Springs C.A<br>Montgomery |
| Rural | Nevada<br>El Dorado C.A<br>Nevada |
| Rural | Newton<br>Mountain Home C.A<br>Newton |
| Rural | Ouachita<br>El Dorado C.A<br>Ouachita |
| Rural | Perry<br>Russellville C.A<br>Perry |

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Phillips<br>Helena C.A<br>Phillips |
| Rural | Pike<br>Hot Springs C.A<br>Pike |
| Rural | Poinsett<br>Jonesboro C.A<br>Poinsett |
| Urban | Polk<br>Fort Smith C.A<br>Polk |
| Rural | Pope<br>Russellville C.A<br>Pope |
| Rural | Randolph<br>Jonesboro C.A<br>Randolph |
| Rural | St. Francis<br>Helena C.A<br>St. Francis |
| Urban | Scott<br>Fort Smith C.A<br>Scott |
| Rural | Searcy<br>Mountain Home C.A<br>Searcy |
| Urban | Sebastian<br>Fort Smith C.A<br>Sebastian |
| Rural | Sevier<br>Texarkana C.A<br>Sevier |
| Rural | Sharp<br>Batesville C.A<br>Sharp |
| Rural | Stone<br>Batesville C.A<br>Stone |
| Rural | Union<br>El Dorado C.A<br>Union |
| Rural | Van Buren<br>Batesville C.A<br>Van Buren |
| Rural | White<br>Batesville C.A<br>White |
| Rural | Woodruff<br>Batesville C.A<br>Woodruff |
| Rural | Yell<br>Russellville C.A<br>Yell |





## Louisiana Health Professional Shortage Area Listing (HPSA)

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | Acadia Parish |
| | Acadia |
| Rural | Allen Parish |
| | Allen |
| Urban | Ascension Parish |
| | Ascension |
| Rural | Assumption Parish |
| | Assumption |
| Rural | Avoyelles Parish |
| | Avoyelles |
| Rural | Beauregard Parish |
| | Beauregard/Dequincy |
| | Beauregard Parish |
| Rural | Bienville Parish |
| | Bienville |
| Rural | Bossier Parish |
| | Northen Bossier |
| | C.T. 0112.00 |
| Rural | Caddo Parish |
| | North Caddo |
| | C.T. 0248.00 |
| | C.T. 0249.00 |
| | C.T. 0250.00 |
| | C.T. 0251.98 |
| Urban | Calcasieu Parish |
| | Beauregard/Dequincy |
| | C.T. 0024.00 |
| | North Lake Charles |
| | C.T. 0002.00 |
| | C.T. 0003.00 |
| | C.T. 0004.00 |
| | C.T. 0014.00 |
| | C.T. 0015.00 |
| | Vinton |
| | C.T. 0035.00 |
| | C.T. 0036.00 |
| Frontier | Cameron Parish |
| | Cameron |
| Rural | Catahoula Parish |
| | Catahoula |
| Rural | Concordia Parish |
| | Concordia |
| Rural | De Soto Parish |
| | De Soto |
| Urban | East Baton Rouge Parish |
| | NW Baton Rouge |
| | C.T. 0001.00 |
| | C.T. 0002.00 |
| | C.T. 0003.00 |
| | C.T. 0004.00 |
| | C.T. 0005.00 |
| | C.T. 0006.01 |
| | C.T. 0006.02 |
| | C.T. 0007.01 |
| | C.T. 0007.02 |
| | C.T. 0011.02 |
| | C.T. 0011.03 |
| | C.T. 0011.04 |
| | C.T. 0030.00 |
| | C.T. 0031.01 |
| | C.T. 0031.02 |
| | C.T. 0033.00 |
| | C.T. 0034.00 |
| Rural | East Carroll Parish |
| | East Carroll |
| Rural | East Feliciana Parish |
| | East Feliciana |
| Rural | Franklin Parish |
| | Franklin |
| Rural | Grant Parish |
| | Grant |
| Rural | Iberia Parish |
| | Iberia |
| Rural | Iberville Parish |
| | Iberville |
| Rural | Jackson Parish |
| | Jackson |
| Rural | Jefferson Parish |
| | Lafitte |
| | C.T. 0277.04 |
| | C.T. 0278.09 |
| | C.T. 0279.00 |
| Urban | Avondale-Westwego |
| | C.T. 0268.00 |
| | C.T. 0269.00 |
| | C.T. 0270.00 |
| | C.T. 0271.00 |
| | C.T. 0272.00 |
| | C.T. 0273.00 |
| | C.T. 0274.00 |
| | C.T. 0275.01 |
| | C.T. 0275.02 |
| | C.T. 0276.01 |
| | C.T. 0276.02 |
| | C.T. 0277.01 |
| Rural | Jefferson Davis Parish |
| | Jefferson Davis Parish |
| Urban | Lafayette Parish |
| | Northeast Lafayette Service Area |
| | C.T. 0001.00 |
| | C.T. 0002.00 |
| | C.T. 0007.00 |
| | C.T. 0008.00 |
| | C.T. 0009.00 |
| | C.T. 0011.00 |

| Rural/Urban | County/Area Name/Parts |
|---|---|
| | C.T. 0012.00 |
| | C.T. 0013.00 |
| Urban | LaFourche Parish |
| | LaFourche |
| Rural | LaSalle Parish |
| | LaSalle |
| Urban | Livingston Parish |
| | Livingston |
| Rural | Madison Parish |
| | Madison |
| Rural | Natchitoches Parish |
| | NW Natchitoches Co |
| | C.T. 9904.00 |
| | C.T. 9907.00 |
| Urban | Orleans Parish |
| | Orleans |
| Urban | Plaquemines Parish |
| | Plaquemines |
| | Plaquemines West |
| | District 5 |
| | District 6 |
| | District 7 |
| | District 8 |
| | District 9 |
| Rural | Plaquemines East |
| | District 1 |
| Rural | Pointe Coupee Parish |
| | Pointe Coupee |
| Rural | Red River Parish |
| | Red River |
| Rural | Sabine Parish |
| | Sabine |
| Urban | St. Bernard Parish |
| | St. Bernard |
| Urban | St. Charles Parish |
| | St. Charles |
| Rural | St. Helena Parish |
| | St. Helena |
| Urban | St. James Parish |
| | St. James |

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | St. John the Baptist Parish |
| | St. John the Baptist |
| Urban | St. Martin Parish |
| | St. Martin |
| Rural | St. Mary Parish |
| | St. Mary |
| Urban | St. Tammany Parish |
| | South Central Slidell |
| | C.T. 0409.00 |
| | C.T. 0411.02 |
| | C.T. 0411.03 |
| Rural | Tangipahoa Parish |
| | Tangipahoa |
| Rural | Tensas Parish |
| | Tensas |
| Urban | Terrebonne Parish |
| | Southern Terrebonne SA |
| | C.T. 0011.00 |
| | C.T. 0012.02 |
| | C.T. 0013.00 |
| | C.T. 0014.00 |
| Rural | Union Parish |
| | Union |
| Rural | Vermilion Parish |
| | Vermilion |
| Rural | Vernon Parish |
| | Vernon |
| Rural | Washington Parish |
| | Washington |
| Urban | Webster Parish |
| | Webster |
| Urban | West Baton Rouge Parish |
| | West Baton Rouge |
| Rural | West Carroll Parish |
| | West Carroll |
| Rural | West Feliciana Parish |
| | West Feliciana |
| Rural | Winn Parish |
| | Winn |

# Louisiana Mental Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | Acadia Parish |
| | Acadia |
| Rural | Allen Parish |
| | Allen |
| Urban | Ascension Parish |
| | Ascension |
| Rural | Assumption Parish |
| | Assumption |
| Rural | Beauregard Parish |
| | Beauregard |
| Urban | Calcasieu Parish |
| | Calcasieu |
| Rural | Cameron Parish |
| | Cameron |
| Urban | East Baton Rouge Parish |
| | East Baton Rouge |
| Rural | East Feliciana Parish |
| | East Feliciana |
| Rural | Iberia Parish |
| | Iberia |
| Rural | Iberville Parish |
| | Iberville |
| Urban | Jefferson Parish |
| | Jefferson |
| Rural | Jefferson Davis Parish |
| | Jefferson Davis |
| Urban | Lafayette Parish |
| | Lafayette |
| Urban | Lafourche Parish |
| | Lafourche |
| Urban | Livingston Parish |
| | Livingston |
| Urban | Orleans Parish |
| | Orleans |
| Urban | Plaquemines Parish |
| | Plaquemines |
| Rural | Pointe Coupee Parish |
| | Pointe Coupee |
| Urban | St. Bernard Parish |
| | St. Bernard |
| Urban | St. Charles Parish |
| | St. Charles |
| Rural | St. Helena Parish |
| | St. Helena |
| Urban | St. James Parish |
| | St. James |
| Urban | St. John the Baptist Parish |
| | St. John the Baptist |
| Urban | St. Martin Parish |
| | St. Martin |
| Rural | St. Mary Parish |
| | St. Mary |
| Urban | St. Tammany Parish |
| | St. Tammany |
| Rural | Tangipahoa Parish |
| | Tangipahoa |
| Rural | Tensas Parish |
| | Tensas |
| Urban | Terrebonne Parish |
| | Terrebonne |
| Rural | Vermilion Parish |
| | Vermilion |
| Rural | Washington Parish |
| | Washington |
| Urban | West Baton Rouge Parish |
| | West Baton Rouge |
| Rural | West Feliciana Parish |
| | West Feliciana |

## Missouri Health Professional Shortage Area Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | Andrew |
| | Andrew |
| Rural | Bates |
| | Bates |
| Rural | Bollinger |
| | Bollinger Co |
| Rural | Caldwell |
| | Caldwell County |
| Rural | Carter |
| | Carter |
| Rural | Cedar |
| | Cedar |
| Rural | Dallas |
| | Dallas |
| Rural | Dekalb |
| | Dekalb County |
| Rural | Harrison |
| | Harrison |
| Rural | Hickory |
| | Hickory County |
| Rural | Holt |
| | Holt |
| Urban | Jefferson |
| | Festus/De Soto |
| | Big River Twp |
| | Central Twp |
| | High Ridge Twp |
| | Imperial Twp |
| | Joachim Twp |
| | Meramec Twp |
| | Plattin Twp |
| | River View Twp |
| | Rock Twp |
| | Valle Twp |
| | Windsor Twp |
| Urban | Lincoln |
| | Lincoln |
| Rural | McDonald |
| | McDonald |
| Rural | Maries |
| | Maries |
| Rural | Mercer |
| | Mercer County |
| Rural | Mississippi |
| | Mississippi |
| Rural | New Madrid |
| | New Madrid |
| Rural | Oregon |
| | Oregon |
| Rural | Osage |
| | Osage |
| Rural | Ozark |
| | Ozark |
| Rural | Pulaski |
| | Pulaski |
| Rural | Putnam |
| | Putnam |
| Rural | Shannon |
| | Shannon |
| Rural | Shelby |
| | Shelby County |
| Urban | Warren |
| | Warren |
| Rural | Washington |
| | Washington |
| Rural | Wayne |
| | Wayne |

### *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.*

## Missouri Mental Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Barton |
| | Joplin Catchment Area |
| | Barton |
| Rural | Butler |
| | Poplar Bluff |
| | Butler |
| Rural | Caldwell |
| | Chillcothe Catchment Area |
| | Caldwell |
| Rural | Carter |
| | Poplar Bluff |
| | Carter |
| Rural | Cass |
| | Lafayette Catchment Area |
| | Cass |
| Rural | Daviess |
| | Chillcothe Catchment Area |
| | Daviess |
| Rural | Dunklin |
| | Poplar Bluff |
| | Dunklin |
| Rural | Franklin |
| | St. Charles Catchment Area/MHSA #16 |
| | Franklin |
| Rural | Grundy |
| | Chillcothe Catchment Area |
| | Grundy |
| Rural | Harrison |
| | Chillcothe Catchment Area |
| | Harrison |
| Rural | Jasper |
| | Joplin Catchment Area |
| | Jasper |
| Rural | Johnson |
| | Lafayette Catchment Area |
| | Johnson |
| Rural | Lafayette |
| | Lafayette Catchment Area |
| | Lafayette |
| Rural | Lincoln |
| | St. Charles Catchment Area/MHSA #16 |
| | Lincoln |
| Rural | Linn |
| | Chillcothe Catchment Area |
| | Linn |
| Rural | Livingston |
| | Chillcothe Catchment Area |
| | Livingston |
| Rural | McDonald |
| | Joplin Catchment Area |
| | McDonald |
| Rural | Mercer |
| | Chillcothe Catchment Area |
| | Mercer |
| Rural | Mississippi |
| | Sikeston Catchment Area (MHSA 20) |
| | Mississippi |
| Rural | New Madrid |
| | Sikeston Catchment Area (MHSA 20) |
| | New Madrid |
| Rural | Newton |
| | Joplin Catchment Area |
| | Newton |
| Rural | Pemiscot |
| | Poplar Bluff |
| | Pemiscot |
| Rural | Putnam |
| | Chillcothe Catchment Area |
| | Putnam |
| Rural | Reynolds |
| | Poplar Bluff |
| | Reynolds |
| Rural | Ripley |
| | Poplar Bluff |
| | Ripley |
| Rural | St. Charles |
| | St. Charles Catchment Area/MHSA #16 |
| | St. Charles |
| Rural | Scott |
| | Sikeston Catchment Area (MHSA 20) |
| | Scott |
| Rural | Stoddard |
| | Sikeston Catchment Area (MHSA 20) |
| | Stoddard |
| Rural | Sullivan |
| | Chillcothe Catchment Area |
| | Sullivan |
| Rural | Warren |
| | St. Charles Catchment Area/MHSA #16 |
| | Warren |
| Rural | Wayne |
| | Poplar Bluff |
| | Wayne |

## PBSI Announces Closure of Albuquerque Office

*Reference: AR – TAM 080406*

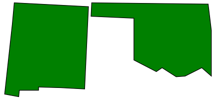
**August 4, 2006:** Pinnacle Business Solutions, Inc. (PBSI), a wholly-owned subsidiary of Arkansas Blue Cross and Blue Shield (ABCBS) has announced the closing of its Albuquerque, New Mexico office. PBSI will maintain a local presence in New Mexico with the continued scheduling of meetings and special seminars for providers by the PBSI Provider Outreach & Education staff.

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

ABCBS assumed the Medicare Part A & B workloads for New Mexico in May of 1997, after Aetna's decision to terminate its Medicare Part B contract.

PBSI Provider Outreach & Education personnel will be available to assist with problems and meet your Medicare educational needs. We are committed to continuing our good working relationship with the New Mexico providers and consider local provider education a priority.

If you have any questions regarding this or other Medicare issues, please contact our provider customer service staff at 1-866-280-6520.



## *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.*

# Physical Therapy – How to Bill Units for 15 Minute Timed Codes

*Reference: January 2006 NL Article on Probe Review Results and OKNM MedGuide – SEE*

In the January 2006 *Medicare Provider News*, we published an article in the Oklahoma/New Mexico state specific section on the result of the probe review for Physical Therapy services. We are publishing this article to remind providers how they should be billing the timed codes for physical therapy. Please see below to ensure you are properly billing your services.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes then 2 units should be billed. Time intervals for larger numbers of units are as follows:

| | | |
|---|---|---|
| **3 units** | **>** | **38 minutes to < 53 minutes** |
| **4 units** | **>** | **53 minutes to < 68 minutes** |
| **5 units** | **>** | **68 minutes to < 83 minutes** |
| **6 units** | **>** | **83 minutes to < 98 minutes** |
| **7 units** | **>** | **98 minutes to < 113 minutes** |
| **8 units** | **>** | **113 minutes to < 128 minutes** |

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for < 8 minutes. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time.

It is advisable that the beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time, see examples below.

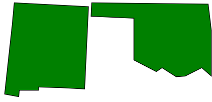
**Example 1:** If 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took more time.

**Example 2:** If a therapist delivers 5 minutes of 97035 (ultrasound), 6 minutes of 97140 (manual techniques), and 10 minutes of 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of 97110 (the service with the longest time) and the clinical record will serve as documentation that the other two services were also performed.

**Note: When submitting redetermination requests or contacting our telephone reopening lines, you will be required to furnish the specific times for each timed service performed. Not supplying these departments with this pertinent information, will result in denial of claim payment.**

**References:**


1. Medicare Part B Local Coverage Determination, *"Physical Medicine and Rehabilitation"*, AC-02-059 available at http://www.oknmmedicare.com/provider/medpolb
2. Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Sections 20.2 and 20.3, available at http://www.cms.gov
3. Web based training regarding *Physical Medicine and Rehabilitation* may be found on the web site http://www.oknmmedicare.com/provider/wbt/default.asp
4. *MedGuide, Physical Therapy*, available at http://www.oknmmedicare.com/provider/medguide/start.htm



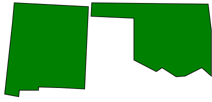


## New Mexico Health Professional Shortage Areas (HPSA)

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County and Area or Parts |
|---|---|
| Frontier | Catron |
| | Catron |
| Rural | Chaves |
| | Chaves Co |
| Rural | Cibola |
| | Cibola Co |
| Rural | Colfax |
| | South Colfax |
| | Cimarron CCD |
| | Springer CCD |
| Frontier | De Baca |
| | De Baca Co |
| Rural | Dona Ana |
| | Hatch |
| | Hatch Division |
| Urban | Southern Dona Ana |
| | Anthony Division |
| | South Dona Ana Division |
| Rural | Grant |
| | Pinos Altos/Mimbres SA |
| | C.T. 9841.00 |
| | Tyrone SA |
| | C.T. 9842.00 |
| Frontier | Quadalupe |
| | Quadalupe |
| Frontier | Harding |
| | Harding |
| Frontier | Hidalgo |
| | Hidalgo |
| Rural | Lea |
| | Lea |
| Frontier | Lincoln |
| | Lincoln |
| Frontier | Luna |
| | Columbus |
| | C.T.0004.00 |
| Rural | McKinley |
| | McKinley |
| Frontier | Mora |
| | Mora Co |
| Rural | Otero |
| | Cloudcroft |
| | Southeast Otero Division |
| Rural | Quay |
| | Quay |
| Frontier | Rio Arriba |
| | Coyote |
| | Coyote Division |
| | Penasco/Truchas/Embudo |
| | Chimayo Division |
| | Dixon Division |
| | Rio Chama |
| | Rio Chama Division |
| | Tierra Amarilla |
| | Tierra Amarilla Division |
| | Vallecitas Division |
| | Western Rio Arriba |
| | Jicarilla Division |
| | Western Rio Arriba Division |
| Urban | Sandoval |
| | Cuba |
| | Cuba Division |
| | Jemez Division |
| | Southern Sandoval |
| | CT 0103.01 |
| | CT 0103.02 |
| | CT 0105.02 |
| | CT 0105.03 |
| | CT 9401.00 |
| | CT 9402.00 |
| Rural | San Juan |
| | San Juan |
| Rural | SanMiguel |
| | Pecos/Villanueva SA |
| | Pecos CCD |
| | Villanueva CCD |
| Urban | Santa Fe |
| | Santa Fe/La Familia |
| | CT 0003.00 |
| | CT 0007.00 |
| | CT 0008.00 |
| | CT 0009.00 |
| | CT 0010.02 |
| | CT 0012.00 |
| | CT 0103.04 |
| Rural | Cerillos/Madrid/Edgewood |
| | C.T. 0103.05 |
| | C.T. 0103.06 |
| | C.T. 0103.07 |
| | C.T. 0103.08 |
| | C.T. 0106.00 |
| | C.T. 0107.00 |
| | C.T. 0108.00 |
| Frontier | Sierra |
| | Sierra |

| Rural/Urban | County and Area or Parts |
|---|---|
| Frontier | Socorro |
| | Socorro |
| Frontier | Taos |
| | Penasco/Truchas/Embudo |
| | Penasco Division |
| | Picuris Division |
| Rural | Questa/Arroyo Hondo |
| | Arroyo Hondo Division |
| | Questa Division |
| Frontier | Torrance |
| | Torrance |
| Frontier | Union |
| | Union |
| Urban | Valencia |
| | Valencia |





## New Mexico Mental Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts | | |
|---|---|---|---|
| Urban | Bernalillo | | |
| | | SW Valley CA | |
| | | | C.T. 0013.00 |
| | | | C.T. 0023.00 |
| | | | C.T. 0024.01 |
| | | | C.T. 0024.02 |
| | | | C.T. 0040.01 |
| | | | C.T. 0043.00 |
| | | | C.T. 0044.01 |
| | | | C.T. 0044.02 |
| | | | C.T. 0045.01 |
| | | | C.T. 0045.02 |
| | | | C.T. 0046.02 |
| | | | C.T. 0046.03 |
| | | | C.T. 0046.04 |
| Frontier | Catron | | |
| | | Border MH SA | |
| | | | Catron |
| Rural | Chaves | | |
| | | Southeastern CA | |
| | | | Chaves |
| Rural | Cibola | | |
| | | Cibola | |
| Rural | Colfax | | |
| | | Colfax | |
| Frontier | Curry | | |
| | | Plains MH Service Area | |
| | | | Curry |
| Frontier | Debaca | | |
| | | Plains MH Service Area | |
| | | | Debaca |
| Urban | Dona Ana | | |
| | | Dona Ana | |
| Rural | Eddy | | |
| | | Southeastern CA | |
| | | | Eddy |
| Frontier | Grant | | |
| | | Border MH SA | |
| | | | Grant |
| Frontier | Guadalupe | | |
| | | Plains MH Service Area | |
| | | | Guadalupe |
| Frontier | Harding | | |
| | | Plains MH Service Area | |
| | | | Harding |
| Frontier | Hidalgo | | |
| | | Border MH SA | |
| | | | Hidalgo |
| Rural | Lea | | |
| | | Southeastern CA | |
| | | | Lea |
| Rural | Lincoln | | |
| | | Southeastern CA | |
| | | | Lincoln |
| Frontier | Luna | | |
| | | Border MH SA | |
| | | | Luna |
| Rural | McKinley | | |
| | | Catchment Area 1 | |
| | | | McKinley |
| Rural | Mora | | |
| | | Mora | |
| Rural | Otero | | |
| | | Southeastern CA | |
| | | | Otero |
| Frontier | Quay | | |
| | | Plains MH Service Area | |
| | | | Quay |
| Rural | Rio Arriba | | |
| | | Rio Arriba | |
| Frontier | Roosevelt | | |
| | | Plains MH Service Area | |
| | | | Roosevelt |
| Urban | Sandoval | | |
| | | Northern Sandoval | |
| | | | Cuba CCD |
| | | | Jemez CCD |
| | | | Santo Domingo CCD |
| Rural | San Juan | | |
| | | Catchment Area 1 | |
| | | | San Juan |
| Rural | Sierra | | |
| | | South Central CA | |
| | | | Sierra |
| Rural | Socorro | | |
| | | South Central CA | |
| | | | Socorro |
| Rural | Taos | | |
| | | Taos | |
| Rural | Torrance | | |
| | | Torrance | |
| Frontier | Union | | |
| | | Plains MH Service Area | |
| | | | Union |
| Urban | Valencia | | |
| | | Valencia | |

# Oklahoma Health Professional Shortage Areas (HPSA)

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County and Area or Parts | | |
|---|---|---|---|
| Rural | Adair | | |
| | | Adair | |
| Rural | Alfalfa | | |
| | | Alfalfa | |
| Rural | Atoka | | |
| | | Atoka | |
| Rural | Choctaw | | |
| | | Choctaw | |
| Frontier | Cimarron | | |
| | | Cimarron | |
| Rural | Coal | | |
| | | Coal | |
| Rural | Cotton | | |
| | | Cotton | |
| Rural | Delaware | | |
| | | Kansas-Colcord | |
| | | | CT.9761.00 |
| | | | CT.9762.00 |
| Frontier | Grant | | |
| | | Grant | |
| Frontier | Harper | | |
| | | Harper | |
| Rural | Haskell | | |
| | | Haskell | |
| Rural | Hughes | | |
| | | Hughes | |
| Rural | Johnston | | |
| | | Johnston | |
| Frontier | Le Flore | | |
| | | Kiamichi Mountain | |
| | | | CT.0407.00 |
| Rural | Lincoln | | |
| | | Lincoln | |
| Urban | Logan | | |
| | | Logan | |
| Rural | Marshall | | |
| | | Marshall | |
| Urban | McClain | | |
| | | McClain | |
| Frontier | McCurtain | | |
| | | Kiamichi Mountain | |
| | | | CT.9982.00 |
| | | | CT.9983.00 |
| Rural | McIntosh | | |
| | | McIntosh | |
| Rural | Nowata | | |
| | | Nowata | |
| Rural | Okfuskee | | |
| | | Okfuskee | |
| Urban | Oklahoma | | |
| | | SE Oklahoma City | |
| | | | CT 1037.00 |
| | | | CT 1038.00 |
| | | | CT 1039.00 |
| | | | CT 1040.00 |
| | | | CT 1041.00 |
| | | | CT 1046.00 |
| | | | CT 1047.00 |
| | | | CT 1048.00 |
| | | | CT 1049.00 |
| | | | CT 1050.00 |
| | | | CT 1053.00 |
| | | | CT 1054.00 |
| | | NE Oklahoma Co. | |
| | | | CT 1080.03 |
| | | | CT 1080.05 |
| | | | CT 1080.10 |
| | | | CT 1080.11 |
| | | | CT 1088.01 |
| | | | CT 1088.03 |
| | | | CT 1088.04 |
| Rural | Pittsburg | | |
| | | Quinton | |
| | | | Quinton Division |
| Rural | Pottawatomie | | |
| | | Konowa | |
| | | | Maud Division |
| | | | Wanette - Asher Division |
| Frontier | Pushmataha | | |
| | | Kiamichi Mountain | |
| | | | CT.9976.00 |
| | | | CT.9978.00 |
| Frontier | Roger Mills | | |
| | | Roger Mills | |
| Rural | Seminole | | |
| | | Konawa | |
| | | | Konawa Division |
| | | | Seminole South Division |
| Rural | Texas | | |
| | | Texhoma | |
| | | | West Texas Division |
| Rural | Tillman | | |
| | | Tillman | |
| Urban | Tulsa | | |
| | | North Tulsa | |
| | | | CT 0002.00 |
| | | | CT 0003.00 |
| | | | CT 0004.00 |
| | | | CT 0005.00 |
| | | | CT 0006.00 |
| | | | CT 0007.00 |

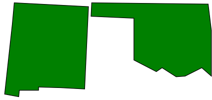
| Rural/Urban | County and Area or Parts |
|---|---|
| | CT 0008.00 |
| | CT 0009.00 |
| | CT 0010.00 |
| | CT 0012.00 |
| | CT 0013.00 |
| | CT 0014.00 |
| | CT 0057.00 |
| | CT 0062.00 |
| | CT 0079.00 |
| | CT 0080.01 |
| | CT 0080.02 |
| | CT 0091.01 |
| | CT 0001.00 |
| | CT 0016.00 |
| | CT 0015.00 |
| | CT 0020.00 |
| | CT 0022.00 |
| | CT 0023.00 |
| | CT 0025.00 |
| | CT 0026.00 |
| | CT 0027.00 |
| | CT 0061.00 |
| | CT 0091.02 |
| | CT 0091.03 |
| Rural | Washita |
| | Washita |

## Oklahoma Mental Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | Adair |
| | Catchment Area 21 |
| | Adair |
| Rural | Alfalfa |
| | Catchment Area 10 |
| | Alfalfa |
| Rural | Atoka |
| | Catchment Area 6 |
| | Atoka |
| Rural | Beaver |
| | Catchment Area 10 |
| | Beaver |
| Rural | Beckham |
| | Catchment Area 9 |
| | Beckham |
| Rural | Blaine |
| | Catchment Area 9 |
| | Blaine |
| Rural | Bryan |
| | Catchment Area 7 |
| | Bryan |
| Rural | Caddo |
| | Catchment Area 8 |
| | Caddo |
| Rural | Carter |
| | Catchment Area 7 |
| | Carter |
| Urban | Cherokee |
| | Catchment Area 21 |
| | Cherokee |
| Rural | Choctaw |
| | Catchment Area 6 |
| | Choctaw |
| Rural | Cimarron |
| | Catchment Area 10 |
| | Cimarron |
| Rural | Coal |
| | Catchment Area 6 |
| | Coal |
| Rural | Comanche |
| | Catchment Area 8 |
| | Comanche |
| Rural | Cotton |
| | Catchment Area 8 |
| | Cotton |
| Rural | Craig |
| | Catchment Area 1 |
| | Craig |
| Urban | Creek |
| | Catchment Area 13 |
| | Creek |

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Custer |
| | Catchment Area 9 |
| | Custer |
| Rural | Delaware |
| | Catchment Area 1 |
| | Delaware |
| Rural | Dewey |
| | Catchment Area 10 |
| | Dewey |
| Rural | Ellis |
| | Catchment Area 10 |
| | Ellis |
| Rural | Garfield |
| | Catchment Area 10 |
| | Garfield |
| Rural | Garvin |
| | Catchment Area 7 |
| | Garvin |
| Rural | Grant |
| | Catchment Area 10 |
| | Grant |
| Rural | Greer |
| | Catchment Area 9 |
| | Greer |
| Rural | Harmon |
| | Catchment Area 8 |
| | Harmon |
| Rural | Harper |
| | Catchment Area 10 |
| | Harper |
| Rural | Haskell |
| | Catchment Area 6 |
| | Haskell |
| Rural | Hughes |
| | Catchment Area 6 |
| | Hughes |
| Rural | Jackson |
| | Catchment Area 8 |
| | Jackson |
| Rural | Jefferson |
| | Catchment Area 8 |
| | Jefferson |
| Rural | Johnston |
| | Catchment Area 7 |
| | Johnston |
| Rural | Kay |
| | Catchment Area 11 |
| | Kay |
| Rural | Kingfisher |
| | Catchment Area 10 |
| | Kingfisher |





| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Kiowa |
| | Catchment Area 9 |
| | Kiowa |
| Rural | Latimer |
| | Catchment Area 6 |
| | Latimer |
| Rural | Le Flore |
| | Catchment Area 6 |
| | Le Flore |
| Rural | Logan |
| | Catchment Area 10 |
| | Logan |
| Rural | Love |
| | Catchment Area 7 |
| | Love |
| Rural | McCurtain |
| | Catchment Area 6 |
| | McCurtain |
| Rural | McIntosh |
| | Catchment Area 16 |
| | McIntosh |
| Rural | Major |
| | Catchment Area 10 |
| | Major |
| Rural | Marshall |
| | Catchment Area 7 |
| | Marshall |
| Rural | Mayes |
| | Catchment Area 1 |
| | Mayes |
| Rural | Murray |
| | Catchment Area 7 |
| | Murray |
| Rural | Muskogee |
| | Catchment Area 16 |
| | Muskogee |
| Rural | Noble |
| | Catchment Area 11 |
| | Noble |
| Rural | Nowata |
| | Catchment Area 1 |
| | Nowata |
| Urban | Okfuskee |
| | Catchment Area 13 |
| | Okfuskee |
| Urban | Okmulgee |
| | Catchment Area 13 |
| | Okmulgee |
| Rural | Osage |
| | Catchment Area 11 |
| | Osage |
| Rural | Ottawa |
| | Catchment Area 1 |
| | Ottawa |

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Rural | Pawnee |
| | Catchment Area 11 |
| | Pawnee |
| Rural | Payne |
| | Catchment Area 11 |
| | Payne |
| Rural | Pittsburg |
| | Catchment Area 6 |
| | Pittsburg |
| Rural | Pontotoc |
| | Catchment Area 7 |
| | Pontotoc |
| Rural | Pushmataha |
| | Catchment Area 6 |
| | Pushmataha |
| Rural | Roger Mills |
| | Catchment Area 9 |
| | Roger Mills |
| Rural | Rogers |
| | Catchment Area 1 |
| | Rogers |
| Rural | Seminole |
| | Catchment Area 7 |
| | Seminole |
| Urban | Sequoyah |
| | Catchment Area 21 |
| | Sequoyah |
| Rural | Stephens |
| | Catchment Area 8 |
| | Stephens |
| Rural | Texas |
| | Catchment Area 10 |
| | Texas |
| Rural | Tillman |
| | Catchment Area 8 |
| | Tillman |
| Urban | Wagoner |
| | Catchment Area 21 |
| | Wagoner |
| Rural | Washington |
| | Catchment Area 1 |
| | Washington |
| Rural | Washita |
| | Catchment Area 9 |
| | Washita |
| Rural | Woods |
| | Catchment Area 10 |
| | Woods |
| Rural | Woodward |
| | Catchment Area 10 |
| | Woodward |

# Physical Therapy – How to Bill Units for 15 Minute Timed Codes

*Reference: RI MedGuide – SEE*

In the February 2006 *Medicare Provider News*, we published an article in the Rhode Island state specific section on the results of the probe review for Physical Therapy services. This article mainly focused on procedure 97012. However, we find the need to inform you once again on the proper way to bill for time codes for physical therapy. Please see below to ensure you are properly billing your services.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes then 2 units should be billed. Time intervals for larger numbers of units are as follows:

| | | |
|---|---|---|
| **3 units** | **>** | **38 minutes to < 53 minutes** |
| **4 units** | **>** | **53 minutes to < 68 minutes** |
| **5 units** | **>** | **68 minutes to < 83 minutes** |
| **6 units** | **>** | **83 minutes to < 98 minutes** |
| **7 units** | **>** | **98 minutes to < 113 minutes** |
| **8 units** | **>** | **113 minutes to < 128 minutes** |

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for < 8 minutes. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time.

It is advisable that the beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time, see examples below.

**Example 1:** If 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took more time.

**Example 2:** If a therapist delivers 5 minutes of 97035 (ultrasound), 6 minutes of 97140 (manual techniques), and 10 minutes of 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of 97110 (the service with the longest time) and the clinical record will serve as documentation that the other two services were also performed.

**Note: When submitting redetermination requests or contacting our telephone reopening lines, you will be required to furnish the specific times for each timed service performed. Not supplying these departments with this pertinent information, will result in denial of claim payment.**

**References:**

1. Medicare Part B Local Coverage Determination, *"Physical Medicine and Rehabilitation"*, AC-02-059 available at http://www.rimedicare.com/provider/medpol/partblmrp.asp
2. Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Sections 20.2 and 20.3, available at http://www.cms.gov
3. Web based training regarding *Physical Medicine and Rehabilitation* may be found on the web site http://www.rimedicare.com/provider/wbt/default.asp
4. *MedGuide, Physical Therapy*, available at http://www.rimedicare.com/provider/medguide/start.htm

## Rhode Island Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | Providence |
| | Northwest Providence |
| | Burrillville Twp. |
| | Foster Twp. |
| | Glocester Twp. |

## Rhode Island Mental Health Professional Shortage Area (HPSA) Listing

*Reference: July 5, 2006, CMS Quarterly Listing*

| Rural/Urban | County/Area Name/Parts |
|---|---|
| Urban | Newport |
| | Newport |
| Urban | Providence |
| | Northern Rhode Island CA |
| | C.T. 0112.00 |
| | C.T. 0113.01 |
| | C.T. 0113.02 |
| | C.T. 0114.01 |
| | C.T. 0114.02 |
| | C.T. 0114.03 |
| | C.T. 0115.00 |
| | C.T. 0116.00 |
| | C.T. 0117.01 |
| | C.T. 0117.02 |
| | C.T. 0128.01 |
| | C.T. 0128.97 |
| | C.T. 0128.98 |
| | C.T. 0129.00 |
| | C.T. 0130.01 |
| | C.T. 0130.02 |
| | C.T. 0172.00 |
| | C.T. 0173.00 |
| | C.T. 0174.00 |
| | C.T. 0175.00 |
| | C.T. 0176.00 |
| | C.T. 0177.00 |
| | C.T. 0178.00 |
| | C.T. 0179.00 |
| | C.T. 0180.00 |
| | C.T. 0181.00 |
| | C.T. 0182.00 |
| | C.T. 0183.00 |
| | C.T. 0184.00 |
| | C.T. 0185.00 |

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Missouri............. (866) 736-0799 ...... www.momedicare.com
Oklahoma .......... (866) 280-6520 ...... www.oknmmedicare.com
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Medicare Communications

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